Hagerstown Family Dentistry
49 W. Walnut Street
Hagerstown, IN 47346
1-765-489-5942

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the ***Notice of Privacy Practices.***

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask us to change the way we contact you.
5. You have the right to ask that we not use or share your health records.

All of these rights are explained in more detail in the Notice of Privacy Practices.

X Signature: _____ Date: _____
(Patient or Legal Representative)

Relationship of Legal Representative: _____

CONSENT:

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you may decline to provide services to me.

X Signature: _____ Date: _____
(Patient or Legal Representative)

Relationship of Legal Representative: _____

REVOCATION OF CONSENT SIGN BELOW ONLY IF YOU REFUSE CONSENT:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written *Notice of Revocation*. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____
(Patient or Legal Representative)

Relationship of Legal Representative: _____