

**Northern Michigan Family Dentistry
Patient Acknowledgment and Consent Form**

Effective April, 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires that this office comply with certain rules regarding the maintenance of the privacy of your information and that we have collected and will collect in the future.

To comply with one of HIPAA requirements, we are giving you a copy of our Notice of Privacy regarding your privacy practices.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity’s functions; a claim for payment of fees; a third party payer’s examination of our records; a court order as part of a criminal investigations; and identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures for your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connections with providing or coordination your treatment.

Patient Acknowledgment and Consent

Please sign and date this form below to acknowledge that you have read a copy of our Notice of Privacy Practices. A copy of our Notice of Privacy Practices is available upon request.

Please sign and date this form to consent to our disclosures of your information that we may deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may be of the type listed above, and those listed in our Notice of Privacy Practices.

Patient Signature (Guardian)

Patient Name (please print)

Date

List Minor Children (print)