104 W. 20th Street, Suite 3
Eudora, KS 66025-8112
Phone (785) 542-9105
Fax (866) 546-8283
eudoradentalcare@johnhhaydds.com
www.johnhhaydds.com

ACKNOWLEDGEMENT AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION (HIPAA)

SECTION A: PATIENT INFORMATION (please print)

Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of This Form: By signing this form, you will consent to our use and disclosure of your protected health Information (PHI) to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this form. Our Notice provides a description of how we use and disclose your PHI for treatment, payment activities, and healthcare operations, of other uses and disclosures we may make of your PHI, and of other important matters about your PHI. A copy of our Notice accompanies this form. We encourage you to read it carefully and completely before signing this form.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

John H. Hay, DDS, Inc.
104 W. 20th Street, Suite 3
Eudora, Kansas 66025-8112

(785) 542-9105
E-mail: eudoradentalcare@johnhhaydds.com

Right to revoke: You have the right to revoke your consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of your consent will not affect any action we took in reliance on this Acknowledgement and Consent before we received your revocation, and that we may decline to treat you or decline to continue treating you if you revoke your consent.

SECTION C: ACKNOWLEDGEMENT AND CONSENT

I acknowledge that I have had full opportunity to read and consider the contents of this Acknowledgement and Consent form and this office's Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent to this office's use and disclosure of my protected health information (PHI) to carry out treatment, payment activities, and healthcare operations, and other uses and disclosures of PHI authorized by law.

Signature: _____ Date _____

If this form is signed by a personal representative on behalf of the patient named at the top, please complete the following:

Personal Representative's Name (please print):_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT