



**MB DENTAL
SOLUTIONS**

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Patient Acknowledgement, Consent, and Authorization 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 that we have collected and will collect in the future. To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our 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 investigation; an 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 of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

(Please note-you may refuse to sign this acknowledgement)

Please sign this form below to acknowledge that you have received a copy of our Notice of Privacy Practices today.

Patient Name (please print)	Signature of Patient, Parent, or Legal Guardian	Date
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Patient Consent

Please sign this form below to consent to our disclosures of your information that we 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 not be of the type listed above

Signature of Patient, Parent, or Legal Guardian	Date
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OFFICE USE ONLY

We attempted to obtain written acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

**Patient refused to sign
signature**

**An emergency situation prevented us from obtaining
signature**

Communication barriers prevented us from obtaining signature Other:



Patient Authorization

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request general dental information, appointment information and financial information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, appointment and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the office of Dr Jason Baker to release my records and any information requested to the following individuals:

1. _____
Name of Person _____ Relation to Patient

2. _____
Name of Person _____ Relation to Patient

3. _____
Name of Person _____ Relation to Patient

4. _____
Name of Person _____ Relation to Patient

Signature _____ Date _____