

MICHAEL STEINBERG, DDS, PC
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

You May Refuse to Sign this Acknowledgement

PATIENT: _____

CHILD (Children names if any): _____

Address: _____

Phone: _____ Email: _____

Social Security Number: _____

Section B: TO THE PATIENT: - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information 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 Consent. Our notice provides a description of our treatment, payment activities, and healthcare options, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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 protected health information 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:

CONTACT PERSON: Pamela Steinberg
PHONE: 480.348.1070 FAX: 480.348.1071
EMAIL: drmsteinberg@cox.net
ADDRESS: PO Box 12009-137 Scottsdale, Arizona 85267

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

CONSENT:

I, _____ have received a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Acknowledgement and Consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

SIGNATURE:

_____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

For Office Use Only:

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

- _____ Individual refused to sign
- _____ Communications barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other (Please specify) _____