HIPAA Acknowledgment and Consent
Greenpoint Pediatric Dentistry

Notice of Privacy Practices and Release of Information

..........(Initials) I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

..........(Initials) I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

 Healthcare information regarding prior encounters with **Greenpoint Pediatric Dentistry** may be made available to subsequent affiliated practices to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

 If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, physician histories and progress notes, emergency records, laboratory reports, operative reports, and nurse's notes.

 Federal and state laws may permit this practice to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

The patient may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent to Email or Text Usage for Reminders and Other Healthcare Communications

The Practice may contact me via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice. The practice does not charge for this service, but standard text messaging rates may apply as provided in my wireless plan.

__________(Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

- The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is____.
- The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is____.

Revocation

I hereby revoke my request for future communications via email and/or text. This revocation only applies to communications from this Practice.

□ I hereby revoke my request to receive any future reminders, feedback, and information via text messages.
□ I hereby revoke my request to receive any future reminders, feedback, and information via email.

Patient/ Guardian Signature:____**Date**:____

Consent for Photographing and Recording for Security and/or Health Care Procedures

__________(Initials) I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

__________(Initials) I do not consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities).

Patient/ Guardian Signature:____**Date**:____