A REASON TO SMILE DENTISTRY, P.A.

ACKNOWLEDGEMENT AND AUTHORIZATION OR REFUSAL OF PRIVACY PRACTICES

To the Patient or Patient's Representative:

The purpose of this form is to acknowledge that you have received our Notice of Privacy Practices and to obtain your authorization or refusal for our Office to use and disclose your/the patient's protected health information for business purposes.

COMPLETE OPTION 1 if you AUTHORIZE our Office to use your/the patient's protected health information for business purposes;

COMPLETE OPTION 2 if you REFUSE to allow our Office to use and disclose your/the patient's health information for business purposes.

OPTION 1

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Purpose of this Authorization: By signing this Authorization section, 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 Authorization. Our Notice provides a description of our treatment, payment activities, and healthcare operations, 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 form. We encourage you to read it carefully and completely before signing this Authorization.

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 Officer: Laura T. Pizzi, PharmD c/o A Reason to Smile Dentistry, P.A.*
Telephone: (609) 426-4500
Fax: (609) 426-1251
E-mail: laura.pizzi@mail.tju.edu
Address: 113 Maplestream Road- Suite 1, East Windsor, NJ 08520

* HIPAA-Trained Privacy Officer for A Reason to Smile Dentistry, P.A.

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

I, _____, have received a copy of A Reason to Smile Dentistry's Notice of Privacy Practices and have had the opportunity to read and consider its contents. I AUTHORIZE this Office to use and disclose my/the patient's protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ **Date:** _____

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

Personal Representative's Name (please print): _____

Relationship to Patient: _____

AT YOUR REQUEST, WE WILL GIVE YOU A COPY OF THIS FORM FOR YOUR RECORDS.

PLEASE COMPLETE THIS FORM THEN RETURN IT TO THE FRONT DESK.

OPTION 2

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES AND REFUSAL TO ALLOW USE AND DISCLOSURE OF HEALTH INFORMATION

You may refuse to authorize our Office to use and disclose protected health information to carry out treatment, payment activities, and healthcare operations. Please keep in mind that your refusal means that:

1. We cannot bill your dental plan to obtain payment for services provided to you, because billing your insurer requires us to share information about the services you received. You must therefore pay us directly for these services, then submit your own claim form to your dental plan, who must reimburse YOU.
2. We cannot disclose your information to other dentists or healthcare providers who treat you (e.g. dental specialists, surgeons, medical physicians, pharmacists, nurses, etc).
3. We cannot remind you about your appointments (through recall postcards, telephone calls/messages, or other communications)

I, _____, have received a copy of A Reason to Smile Dentistry's Notice of Privacy Practices and have had the opportunity to read and consider its contents. I DO NOT AUTHORIZE this Office to use and disclose my/the patient's protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

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

Personal Representative's Name (please print): _____

Relationship to Patient: _____

AT YOUR REQUEST, WE WILL GIVE YOU A COPY OF THIS FORM FOR YOUR RECORDS.

For Office Use Only:

Attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and patient's authorization or refusal on _____ (DATE), but this could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited their completion of this form
- ☐ An emergency situation prevented us from obtaining their completion of this form
- ☐ Other (please specify below):

_____

PLEASE COMPLETE THIS FORM THEN RETURN IT TO THE FRONT DESK.