Dr. Beth Yamashiro
9480 S Eastern Ave. Ste 145
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www.bethsbraces.com

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Beth's Braces HIPAA Notice of Privacy Practices Receipt Acknowledgment

I, (Patient Name)___________________________________ understand that as part of my health care, Beth's Braces originates and maintains health records describing my health history, symptoms, examinations, test results, diagnosis, treatment, and any plans for future care or treatment.

I acknowledge that I have received Beth's Braces 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. 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.

I understand that:

- I have the right to review Beth's Braces Notice of Privacy Practices prior to signing this acknowledgement;
- that Beth's Braces reserves the right to change their Notice of Privacy Practices and prior to implementation will mail a copy of any revised notice to the address I've provided if I request it.

Signature of Individual or Legal Representative Witness ________________________________

Printed Name of Individual or Legal Representative Witness _____________________________

Date:____________________________

FOR OFFICE USE ONLY

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

__ Individual refused to sign
__ Communication barriers prohibited obtaining the acknowledgement
__ An emergency situation prevented us from obtaining acknowledgement
__ Others (please specify)

____
____

___________________________________ __________________________

Jordan Smith
Privacy Official

Date

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Beth's Braces HIPAA Acknowledgment and Consent Form

______ (Patient/Parent initials) **Release of Information**. I hereby permit practice and the dentist or other health professionals involved in my care to release healthcare information for purposes of treatment, payment, or healthcare operations. Healthcare information may be made available to subsequent health care facilities 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. Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities 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. I understand that this facility may be a member of one or more such organizations. This consent specifically includes, but is not limited to, information concerning physical conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases.

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:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications: Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, 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.

______ (Patient 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: (Phone #):____________________________
Cell Phone Service Provider:__________________________.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is (email):____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

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*Revocation: (only fill out if you do **NOT** want emails/ texts)*

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: ____

Patient/Patient Representative Signature: ___________________________

Date: ______________________ Time: _______________

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ (Patient/Parent 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.

Consent to the Use and Disclosure of Protected Health Information
for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review Beth's Braces Notice of Privacy Practices prior to signing this consent;
- That Beth's Braces, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Beth's Braces, is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that Beth's Braces, has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: ______________________________

Printed Name of Patient or Legal Representative Witness: ___________________________

Date: ______________