CHAPMAN ORTHODONTICS
Peter L. Chapman, D.D.S., M.S.D.

and related professional corporations

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

☐ By initialling this box, I give permission to discuss orthodontic treatment and scheduling issues with anyone who brings in or comes with my child for treatment appointments

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement 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)

HIPAA Contact Consent and Authorization for Disclosure of Protected Health Information

I, _____, Date of Birth: ___/___/_____, consent to and authorize the disclosure of my Protected Health Information under HIPAA, which may include my name, diagnosis, prognosis, test results, and the date and description of all treatment needed as well as received, including all financial information related to these services, to the people listed below:

NAME AND ADDRESS	RELATIONSHIP	TELEPHONE NUMBER

You have the right to revoke this Consent and Authorization at any time by giving us written notice of your revocation submitted to the contact person listed on our Notice of Privacy Practices. Please understand that revocation of this Consent and Authorization will *not* affect any action we took in reliance on this Consent and Authorization *before* we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent and Authorization.

Please indicate with a check mark if we may leave messages pertaining to your Protected Health Information on the following automated systems:

Answering machine:	Home	Yes_____	No_____
Answering machine:	Work	Yes_____	No_____
Voicemail:	Home/Cell	Yes_____	No_____
Voicemail:	Work	Yes_____	No_____
E-mail:		Yes_____	No_____
Other: _____		Yes_____	No_____

_____ _____
Printed Name of Patient Social Security Number

_____ _____
Patient Signature (Parent or Guardian, if Minor) Date

_____ _____
Witness Date