



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

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### For Office Use Only

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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)

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[www.drchapmanorthodontics.com](http://www.drchapmanorthodontics.com)

*Orthodontics of Central Indiana, P.C.*

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ZIONSVILLE 1455 West Oak Street, Suite A | Zionsville, IN 46077 | 317.873.5566 WEST 10th STREET 6443 West 10th Street, Suite 204 | Indianapolis, IN 46214 | 317.484.6388

## 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