Serene Smiles Dentistry
Dr. Rachel J. Swart, D.D.S., PA

HIPPA Acknowledgment of Receipt of Privacy Practices and Authorization for Release of Information

Patient Name: _____ **DOB:** _____

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Serene Smiles Dentistry is authorized to release protected health information regarding the above-named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Person's Name & Phone Number: _____

- □ Financial
- □ Medical/Dental Information
- □ Other: _____

Additional Person's Name & Phone Number: _____

- □ Financial
- □ Medical/Dental Information
- □ Other: _____

PATIENT E-MAIL AND TEXT MESSAGING

Due to the changing world of healthcare and technology, we now have the ability to provide our patients with certain types of information via e-mail and/or text messaging.

We believe strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. In order to protect your privacy, no confidential or personal information will be sent from us via email or text messaging. We do not share the names, e-mail addresses, and/or telephone numbers of patients with any other companies, or with any other patient.

By placing my name and date below, I acknowledge that I have read and understand the above statement on emails and text messages. Should I have any questions, I can contact the practice at any time. I hereby give permission to send messages to me via email and/or text messaging as means of communication.

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal and state law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ Date: _____
Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)
_____
_____