Smile Linn Dental
Family Dental Care

Hipaa Consent for use/disclosure of Health Information

Notice: Smile Linn Dental staff are committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice This notice takes effect on April 2003 and will remain in effect until we replace it.

Consent: By signing this form, you consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

Right to Revoke: You have the right to revoke this consent at anytime by giving us written notification. We will honor the request from the day we received your written notification. Please understand that it will not affect any action taken before we received the revocation and we may decline to treat you or continue treating you if you revoke this consent.

Changes to Privacy Policies: We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

Patient Responsibility: We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

Contact Information: You may obtain a copy of Notice of Privacy Practices by contacting Dr Ibsies at (503) 607-2222 or mailing us your request in writing to:
Smile Linn Dental 18750 SW Willamette Dr Suite B2 West Linn Oregon 97068
Attention Dr Ibsies

I, _____ have received a copy of this office's Notice of Privacy Practices. I also agree to give my consent for Dr Fadi Ibsies DMD & staff to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

Patient Name: _____ Patient Signature: _____
Responsible Party Name:_____ Relationship to patient: _____
Responsible Party Signature: _____ Date_____

For Office Use Only: We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices but it could not be obtained because:
_____ Individual refused to sign
_____ Communication barrier kept us from obtaining acknowledgement
_____ A emergency situation kept us from obtaining acknowledgement
_____ Other _____