

**Stephen A. Mabry, DDS, PLC**  
*Acknowledgement of Receipt  
of  
Notice of Privacy Practices-HIPAA  
and  
Consent for Use and Disclosure of Health Information*

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

My signature below confirms the following:

I have received a copy of the *Notice of Privacy Practices*.

If, at some time, I wish to receive a copy of my dental records, or I wish to have a copy of my dental records sent to another health provider's office, this paper serves as my written request.

I consent that, under certain circumstances, this office may use and disclose my health information as described in the *Notice of Privacy Practices* for treatment, payment, and healthcare operations.

This includes my consent for this office to perform the following:

- i) To use my name for lab work
- ii) To use my Social Security Number only as required by my insurance company; or other appropriate people; and/or in the case of non-payment, a collection agency or attorney
- iii) To discuss, as part of conducting healthcare operations, my healthcare and personal information with other doctors; lab technicians; insurance companies; or other appropriate people; and/or in the case of nonpayment, a collection agency or attorney
- iv) To leave appointment information by such means as voice-mail, e-mail, postcards, verbal messages given to a family member, or other person answering home or work telephone
- v) To leave or request other information by such means as voice-mail, e-mail, verbal messages given to a family member or other designated person (Examples: We need further insurance information; your x-rays show you need a filling; etc.)

Name/s: \_\_\_\_\_ Relationship \_\_\_\_\_

Please print names of family member/s and/or other designated personals with whom we may disclose healthcare information. Write NONE, if in "iv)" and "v)," you do not want this office to discuss your healthcare with anyone but you and those mentioned in the *Notice of Privacy Practices*.

I acknowledge that even though Dr. Mabry's staff will always attempt to be discrete, the configuration of the office is such that occasionally, others may hear our discussions. I understand that in such a situation, I may ask that we continue our conversation in a private area.

I acknowledge that I may revoke my consent to the above at any time by notifying Dr. Mabry in writing with the understanding that upon revoking my consent, Dr. Mabry the right to decline to treat me or to continue to treat me.

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Signature of Patient or Personal Representative

Relationship if other than self

Date