The Huntington Group, P.C.

Acknowledgment & Consent to Use and Disclosure of Health Information

SECTION A: PATIENT GIVING ACKNOWLEDGMENT/CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail (optional) : _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: In order to comply with certain federal and state laws, we are required to obtain your written consent prior to making use or disclosing your personal health information. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Acknowledgment/ Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Acknowledgment/Consent. We encourage you to read it carefully and completely before signing this Acknowledgment/Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person:	David M. Rombach, DDS, MD
Telephone:	248.547.8833
Fax:	248.547.8836
Address:	26111 Woodward Avenue Huntington Woods, Michigan 48070

Right to Revoke: You will have the right to revoke your Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

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

Signature: _____ Date: _____

If this Acknowledgment/Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices and Consent. We were unsuccessful in obtaining the patient's signature for the following reason(s):

- ❑ Individual refused to sign
- ❑ Communication barrier(s) prohibited obtaining the patient's signature
- ❑ An emergency situation prevented us from obtaining the patient's signature
- ❑ Other (please specify):_____

Revised 03/05