SCHOHARIE DENTAL

HIPAA Form

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have read a copy of the Notice of Privacy Practices for the offices of Schoharie Dental, PLLC. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Schoharie Dental, PLLC uses E-Prescribing, which allows the prescriber to send prescriptions electronically to a pharmacy, to have information about which drugs are covered by the drug benefit plan, and to have information about medications the patient is already taking. By signing this consent form, you are agreeing that Schoharie Dental can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY □ YES □ NO

SPOUSE ONLY □ YES □ NO

OTHER (PLEASE SPECIFY): □ YES □ NO

_____

Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

The Notice of Privacy Practices could be downloaded at www.schohariedentalny.com

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