# Privacy Practices (HIPAA) Consent & Acknowledgement

# Glass City Endodontics

Matthew Nakfoor, D.D.S.
Matthew Dietrich, D.D.S.
Darya Dabiri, D.D.S.
Practice Limited to Endodontics
3900 Sunforest Court Suite 232
Toledo, Ohio 43623
419-472-7668

Name:_____

Address:_____

_____

Home phone:_____

Cell Phone:_____

Email:_____

*Are We Allowed to Leave a Detailed Message?*

YES NO

***It is your responsibility to keep phone numbers, email and address up to date.***
*We will confirm appointments via phone calls.*

## Information Release

To Whom Are We Allowed To Release Your Patient Health Information To?

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

Name:_____ Relationship:_____

Phone:_____

## Notice of Privacy Practices

I acknowledge that I have read and understand the Privacy Practice Notice (HIPAA).
We will only use your Patient Health Information (PHI) for the purpose of treatments, payments, healthcare operations, and coordination of care.

I authorize the transfer of radiographs and dental records for referred treatment and in the event of transfer to another general dentist.

I understand that I have the right to revoke this authorization, in writing, at anytime by notifying the office.

_____

Patient Signature (Parent/Guardian) Date

** Patient refuses to sign _____ (office Administrator Initials) Date: