Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN THE FORM BELOW UNDER THE HEADING "ACKNOWLEDGEMENT" TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE TO PRIVACY PRACTICES.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with:

1. A defense to a claim challenging our professional competence;
2. A review entity's functions;
3. A claim for payment of fees;
4. A third party payer's examination of our records;
5. A court order as part of a criminal investigation;
6. An identification of a dead body;
7. A licensure investigation; or
8. A child abuse/ neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

PLEASE SIGN THE FORM BELOW UNDER THE HEADING "CONSENT" TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

Suttons Bay Dental Center PLLC
Acknowledgement of Receipt of Notice of Privacy Practices and
Consent for Use and Disclosure of Health Information

Patient Giving Acknowledgement and Consent

Name: ____

Address:____

Telephone:_______________________________ **E-mail:**_____________________________________

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this 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 Consent and Acknowledgement form. We encourage you to read it carefully and completely before signing.

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.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to a Contact Person listed on the bottom of this form. 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 continue treating you if you revoke this Consent.

<u>Acknowledgement of Receipt of Notice of Privacy Practices</u>

I, ______________________________________, have received a copy of this office's Notice of Privacy
(Please Print Name)
Practices.

________________________________ __________

(Signature) **(Date)**

<u>Consent for Use and Disclosure of Health Information</u>

I, ______________________________________, have had full opportunity to read and consider the
(Please Print Name)
contents of this Consent form and your Notice of Privacy Practices. I understand that , by signing this Consent form, I am giving my consent to your use and disclosures of my protected health information to carry out treatment, payment activities and health care operations.

________________________________ __________
(Signature) **(Date)**

If this form is signed by a personal representative on behalf of the patient, please complete the following:
Personal Representative Name:____
Relationship to Patient____

Contact Persons: Steven D Hall DDS or John D Holcombe DDS
Telephone: 231-271-6700 Fax: 231-271-5093
Address: 1299 S West Bay Shore Drive, Suttons Bay, MI 49682