



Dr. James M. Kelly, D.M.D. (D.D.S.), P.C.
Dr. Marcy M. Murrell, D.M.D.
16000 N. Haggerty Road
Plymouth, MI 48170
(734) 420-8300

Patient HIPPA and Acknowledgement and Consent Form
(Must Be Completed and Returned By Patient Prior To Treatment)

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.

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with; a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

To the Use and Disclosure of Health Information for Treatment, Payment, or health care Operations I, _____, understand that as part of my health care, Haggerty Dental Associates originates and maintains paper and/or electronic records describing my health history, symptoms, examination, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and will be provided, upon request, with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Haggerty Dental Associates is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Haggerty Dental Associates reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Haggerty Dental Associates change their notice, they will send a copy of any revised notice to the address I've provided.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Can confidential messages be left on your answering machine or voicemail? YES NO

Please list, if any, person(s) whom we may inform about your medical condition, diagnosis, and/or financial account:

Name: _____	Phone Number: _____
Name: _____	Phone Number: _____
Name: _____	Phone Number: _____

I wish to have the following restrictions to the use or disclosure of my health information:

I fully understand and accept decline the terms of this consent.

Patient's Signature

Date

FOR OFFICE USE ONLY

- Consent received by _____ on _____
- Consent refused by patient, and treatment refused as permitted.
- Consent added to the patient's medical record on _____