HENLEY & KELLY
COSMETIC • FAMILY • DENTISTRY

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NOTICE OF PRIVACY PRACTICES CONSENT FORM

I, _____ understand the Health Insurance Portability and Accountability Act of 1995 (HIPPA). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the used and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Dr. C.J. Henley or Dr. J. Craig Kelly have the right to change their Notice of Privacy Practices from time to time and that I may contact the office's privacy officer at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is to be used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions,

I understand that I may revoke this consent in writing at time, except to the extent that you have taken actions relying on such consent.

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ other (Please specify): _____