

LING FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES & CONSENT FOR USE AND  
DISCLOSURE OF HEALTH INFORMATION

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Patient Name. \_\_\_\_\_

Address. \_\_\_\_\_

Telephone. \_\_\_\_\_

**TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

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

**Notice of Privacy Practice:** 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 other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

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. These changes may apply to any of your protected health information that we maintain. You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

**Michael D Ling, DDS-Privacy Officer**  
**Telephone: 763-784-1993 Fax: 763-784-1575**  
**10945 Ulysses Street NE**  
**Blaine, Minnesota 55434**

**Consent Does Not Expire after One Year.** By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. 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. You may obtain a revocation of consent form upon request.

**SIGNATURE:** I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature. \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: \_\_\_\_\_

NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

## PATIENT COMMUNICATION FORM

**A. FAMILY AND FRIENDS:** It is the office policy of this Practice not to release confidential medical and health information regarding your treatment to family members or friends, except for 1) parent/legal guardian; 2) other persons authorized by the patient; 3) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that the person is entitled to receive information regarding your treatment); 4) in emergency situations, or 5) as otherwise permitted by the Health Insurance Portability and Accountability Act (HIPAA).

If you anticipate that you will need or want your medical or health information to be provided to family members, friends, or caretakers/babysitters, please sign below so that we can release that information to that person. If you do not want any of your medical or health information provided to a family member or friend, please circle the no' response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing.

You may cancel this authorization to the extent allowed by law. If you do, you understand that the doctor or Practice may have already released information about you after you gave permission. You understand that cancelling this authorization would not prohibit any release of information by the Practice in reliance on your original authorization. If you wish to cancel or change this agreement, please issue a letter in writing to Michael D. Ling, DDS.

	Health Care Information	Financial Information
Spouse _____	Yes/No	Yes/No
Parent _____	Yes/No	Yes/No
Other _____	Yes/No	Yes/No
_____	Yes/No	Yes/No



**B. ALTERNATIVE COMMUNICATIONS:** You are also entitled to specify alternative, reasonable means of communication, if you do not want to be contacted in a certain way.

I hereby request the following means of contact only \_\_\_\_\_

**C. TELEPHONE COMMUNICATIONS:** In order for Ling Family Dentistry to communicate with our patients regarding scheduling, appointments and billing by telephone; we must have authorization to convey designated information.

I Authorize Ling Family Dentistry to leave any related information regarding my care at  
 Home Telephone/Voicemail    Cell Telephone/Voicemail    Work Telephone/Voicemail

**D. ELECTRONIC ONLINE COMMUNICATION:**

By signing below I agree that this practice may electronically communicate with me at the following e-mail address and text number regarding my family/patient account and/or information about any dental visit and/or treatment (Upcoming or Past).

E-Mail Address: \_\_\_\_\_ Text Number: \_\_\_\_\_

By utilizing our practice's automated electronic communication services, you agree that Ling Family Dentistry may send to you any that you identify as communication that can be sent through the Internet or automated program(s) to an e-mail or text that you designate. Online communications that we are affiliated with do not sell, share or rent users' personally identifiable information unless required by law, do not send e-mail or other communications without user permission, and do not send spam. All electronic communications from our practice will be encrypted, I am responsible for providing this dental practice any updates to my e-mail address and text. I am able to receive information electronically and store it securely away from any public computer and I can withdraw my consent to electronic communications by calling our office @ 763-784-1993.

**E. LATE CANCEL-FAIL PRACTICES:** Your scheduled appointment with Ling Family Dentistry is time reserved just for you. If an appointment change is necessary, kindly give our office a minimum notification of two business days. Failing or short-notice cancellation of a scheduled appointment with our office could result in minimum fee of \$50.00 and possible discontinuation of future appointments.

**F. SPECIAL NOTICE SUBSTANCE USE DISORDER (SUD) RECORDS (42 CFR PART 2)**

If we create, maintain, or receive SUD records protected by 42 CFR Part 2, those records are subject to additional protection. Part 2 prohibits us from using or disclosing SUD records for many purposes without your written consent, including certain treatment, payment, and health care operations. Part 2 records generally may not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you without your written consent or a specific court order. You may revoke your consent as permitted by Part 2. We may combine this notice with Part 2 Patient Notice so long as all required elements are included.

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Patient    Parent    Legal Guardian   Signature Date

YOU MAY REQUEST A COPY OF THIS RELEASE

