

HIPAA

Due to the Health Insurance Portability & Accountability Act (HIPAA), Dr. Diana T. Brawka and Dr. Gina M. Jacobsen request that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you acknowledge the receipt of our Notice of Privacy Practice provided by Dr. Diana T. Brawka, DDS, PC. By signing this form, you also consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

Name of Patient: _____ (please print)

Signature of Patient/Responsible Party: _____ Date: _____

Authorization to Release Information to Family Members

Including Voicemail, In-Person, or Other Authorized Forms of Communication

I hereby authorize Dr. Diana T. Brawka/Dr. Gina M. Jacobsen or staff the right to leave detailed messages/voicemails at the following telephone number provided and/or with the following individuals listed below related to specific appointment information, laboratory/pathology results, patient instructions, follow-up care descriptions, social work coordination, prescription refill status, referral, billing, and insurance information.

HOME: Yes___ No___ CELL: Yes___ No___ BUSINESS: Yes___ No___

Note: If permission is not granted, only the date, time and location of your appointment will be left on your answering machine/voicemail.

For Contact with Me Personally:

Telephone Number (including area code): _____

AND/OR

For Contact with Another Adult Individual(s):

1. Name: _____ Relation to Patient: _____ Phone: _____

2. Name: _____ Relation to Patient: _____ Phone: _____

Signature of Patient/Responsible Party: _____ Date: _____

My signature below represents my voluntary request to make the above assignments and my full legal authority to do so. I acknowledge that I have received a copy of the Dr. Diana T. Brawka, DDS, PC Notice of Privacy Practices. I understand this document provides additional information about the use/disclosure of my protected health information.

Signature of Patient/Responsible Party: _____ Date: _____

For Office Use only

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

- Individual refused to sign
- An emergency situation prevented us from obtaining acknowledgement
- Communication barrier prohibited obtaining the acknowledgement
- Other (please specify) _____