Print Form

HIPAA PRIVACY RULE
PATIENT AUTHORIZATION & ACKNOWLEDGEMENT AGREEMENT

Authorization for the disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.508 (a)).

I, _____ understand that as part of my health care, Tereza Hambarchian, D.D.S., Glendale, CA, originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care of treatment. I understand that this information serves as:

* A basis for planning my care and treatment;
* A means of communication among the health professionals who may contribute to my health 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;
* A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Information Practices that provides a more complete description of information uses and disclosures.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the use and disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506 (a))

I understand that:

* I have the right to review Tereza Hambarchian, D.D.S. - Glendale, CA, Notice of Information practices prior to signing this consent;
* Tereza Hambarchian, D.D.S. - Glendale, CA, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I have provided, if request;
* I have the right to object to the use of my health information for directory purposes;
* I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or health care operations and that Tereza Hambarchian, D.D.S. - Glendale, CA, has already taken action in reliance thereon.

Signature of patient or responsible person: _____

Patient Name: _____ Current Date: _____

For Office Use Only

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

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