Akoya Pediatric Dentistry
15761 Sheridan St, Suite A, Southwest Ranches, FL 33331
(954) 799-6212

# Notice of Privacy Practices Acknowledgement and Consent

PATIENT FIRST NAME

PATIENT LAST NAME

DATE OF BIRTH (MM/DD/YYYY) *

MM/DD/YYYY

I acknowledge the receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctors/facilities in the future.

**STATEMENT OF PRIVACY POLICY**

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices, however, we will always inform you of any changes that might affect your rights.

**Protecting Your Personal Healthcare Information**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Florida. This included issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

**Collecting Protected Health Information [PHI]**

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number[s], Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

**Disclosure of Your Protected Health Information**

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Any break in the protection of your personal health information, including unauthorized acquisition, access, use or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

**Your Rights as Our Patient**

You have a right to request copies of your healthcare information, to request copies in a variety of formats, and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law, if your  believe your rights have been violated, we urge you to notify us immediately at [954]-799-6212.

You can also notify the U.S. Department of Health & Human Services.

**I authorize the following individuals (example: spouse, parent/grandparent, sibling) to have access to and be informed of this patient's dental/medical information and dental/medical care:**

NAME:

RELATIONSHIP TO PATIENT:

NAME:

RELATIONSHIP TO PATIENT:

NAME:

RELATIONSHIP TO PATIENT:

**If you do not list anyone, we WILL NOT share any information regarding your account.**

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY CHILD/S APPOINTMENTS, TREATMENT, AND BILLING INFORMATION VIA: *

- [ ] Cell Phone Confirmation
- [ ] Home Phone Confirmation
- [ ] Work Phone Confirmation
- [ ] Text Messages to my Cell Phone
- [ ] Any of the above

I AUTHORIZE INFORMATION ABOUT MY CHILD/S HEALTH BE CONVEYED VIA: *

- [ ] Cell Phone Confirmation
- [ ] Home Phone Confirmation
- [ ] Work Phone Confirmation
- [ ] Text Messages to my Cell Phone
- [ ] Email Confirmation
- [ ] Any of the above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUNDRAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS OFFICE VIA: *

- [ ] Phone Message
- [ ] Text Messages
- [ ] Email
- [ ] Any of the above
- [ ] None of the Above (opt out)

In signing this HIPAA Patient Acknowledgement Form, I acknowledge and authorize that this office may recommend products or services to promote my improved health. This office may or may not receive third party remuneration from these affiliated companies. This office, under current HIPAA Omnibus Rule, will provide me with this information with my knowledge and consent.

DRAW YOUR SIGNATURE INTO THE BOX BELOW *

Clear

RELATIONSHIP TO THE PATIENT

NAME IF NOT THE PATIENT

DATE

04-29-2025

## FOR OFFICE USE ONLY

AS PRIVACY OFFICER, I ATTEMPTED TO PARENT/CAREGIVERS WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, HOWEVER, ACKNOWLEDGEMENT COULD NOT BE OBTAINED BECAUSE:

NAME OF PRIVACY OFFICER: