

BRIAN BAILEY, DDS, P.C.

**HIPAA PRIVACY ACT FORM &
IDENTITY THEFT POLICY**

CONSENT FOR USE and DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient Name _____ . Date of Birth _____ .

Name of signer on behalf of the patient _____ .

Relationship to patient _____ .

Purpose of Consent: By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare options. This may include disclosing your information to labs, specialists and insurance companies. Our Notice of Privacy Practices form outlines the important information about your protected health information. We encourage you to read it carefully before signing this form.

I give my consent to Dr. Brian Bailey's office for use and disclosure of my protected health information to carry out treatment, payment activities and healthcare options.

Signature _____ . Date _____ .

SECTION B: DESIGNATION OF RELEASE OF HEALTH INFORMATION

Dr. Brian Bailey's office adheres to a policy of not releasing protected health information to individuals other than the patient or personal representative. By indicating below, you can designate other to receive your health information. **Please choose and mark one of the options below:**

___ . Option A: I choose to have my health information released only to me

___ . Option B: I authorize Dr. Brian Bailey's office to release protected healthcare information about myself to the following individual(s):

Name _____ . Relationship _____ .

Name _____ . Relationship _____ .

Dr. Brian Bailey's office reserves the right to change their privacy practices as described in the Notice of Privacy Practices. If changes are made a revised Notice of Privacy Practices will be issued. **You may obtain a copy of our Notice of Privacy Practices any time by contacting Dr. Brian Bailey's office.**

Contact Person Eline Morabito

Office Phone (989) 631-6075

Address 308 Dartmouth Dr., Ste 1, Midland, MI 48642

Right to Revoke: You will have the right to revoke consent at any time by giving Dr. Brian Bailey's office a written notice of your revocation, submitted to the Contact Person listed on the front of this form. Please understand that revocation of consent will not affect any action we took previous to receiving your revocation. **If you revoke this consent we may decline to treat you or to continue to treat you.**

For Office Use Only

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

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Must specify):

Name of Staff Member _____ Date _____

Identity Theft Policy

Effective November 1, 2009, the practice of Brian Bailey D.D.S., P.C., established an Identity Theft Prevention Program ("Program") designed to detect, prevent, and mitigate identity theft. This Program enables Brian Bailey, D.D.S., P.C., to protect patients, reduce risk from identity fraud, and minimize potential damage to itself and the patients from fraudulent activity.