



**Neighborhood Smiles - Ryan Yakowicz, DDS**  
**120 Greenway Cross Court, Belleville, WI 53508**

## **PATIENT ACKNOWLEDGEMENT AND CONSENT FORM**

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Wisconsin Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to obtain written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

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### **PATIENT ACKNOWLEDGEMENT AND CONSENT**

*PLEASE SIGN THIS FORM BELOW TO ACKNOWLEDGE THAT YOU HAVE TODAY RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES AND THAT YOU CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.*

**Signature** \_\_\_\_\_

**Print Name** \_\_\_\_\_ **Date** \_\_\_\_\_

### **AUTHORIZATION TO RELEASE INFORMATION**

I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
Relationship

*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
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify) \_\_\_\_\_