DR. JACK "CHIP" CASE, JR., DDS, MS
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ORTHODONTIC SPECIALISTS TREATING ADULTS & CHILDREN

NOTICE OF PRIVACY PRACTICES

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient First and Last Name: ____

Responsible Party Name: ____

Relationship to Patient: ____

Signature of Responsible Party: _____________________________________ **Date:** ________________________

***TURN PAGE OVER TO COMPLETE. THE INFORMATION ON THE BACK SIDE OF THIS FORM IS NECESSARY.**

Office Use Only: *I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:*

Date	Initials	Reason

HIPAA AUTHORIZATION FOR
RELEASE OF INFORMATION TO FAMILY AND/OR FRIENDS

Patient First and Last Name: ____________________________________ Date of Birth: _______________

CASE ORTHODONTICS IS AUTHORIZED TO RELEASE PROTECTED HEALTH INFORMATION ABOUT THE ABOVE NAMED PATIENT TO THE FOLLOWING LISTED ENTITIES:

Entity name: ___________________________________ Relationship: _________________

Entity name: ___________________________________ Relationship: _________________

Entity name: ___________________________________ Relationship: _________________

PLACE A CHECK MARK BY EACH SITUATION GIVING CASE ORTHODONTICS YOUR AUTHORIZATION TO SUPPLY INFORMATION TO YOUR ENTITY:

_____Text message (for text communication, I understand that if text is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive text communication.)

_____ Leave information on voice mail

_____ Give information to grandparent

_____ Release financial information

_____ Give information to parent (patient is over 18 years of age)

_____ Give information to spouse

_____ E mail

_____ Medical information as follows: ___________________________________

_____Other information as described: ____________________________________

RIGHTS OF THE PATIENT: READ AND SIGN BELOW

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT I HAVE THE RIGHT TO INSPECT OR COPY THE PROTECTED HEALTH INFORMATION TO BE DISCLOSED AS DESCRIBED IN THIS DOCUMENT BY SENDING A WRITTEN NOTIFICATION TO CASE ORTHODONTICS. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE IN CASES WHERE THE INFORMATION HAS ALREADY BEEN DISCLOSED BUT WILL BE EFFECTIVE GOING FORWARD.

I UNDERSTAND THAT INFORMATION USED OR DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT MY TREATMENT WILL NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.

THIS AUTHORIZATION SHALL BE IN FORCE AND EFFECT UNTIL REVOKED BY THE PATIENT OR REPRESENTATIVE SIGNING THE AUTHORIZATION.

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Signature of Patient/Responsible Party/Legal Guardian/Personal Representative Date