PATIENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

DR. CHARLES STANFIELD

Patient's Name (Please Print) _____ Date of Birth _____

Signature of Patient or Representative _____ Date _____

Relationship of Representative to Patient _____

___ I have been given a copy of the Notice of Privacy Practices of this office as requested by me.

___ I did not request a copy of the Notice of Privacy Practices of this office but have seen and reviewed this document in the reception area of this office.

Your signature on this receipt will allow us to disclose your health information and appointment dates for the purpose and safety of your dental treatment. It will also be used to obtain your payment reimbursement for t services we would provide for you (ie: insurance company either by electronic e-mail or fax) as well as permission to disclose your health information to the following person (s); your physician if deemed necessary for your dental treatment needs, your pharmacy for medical prescriptions relating to your treatment needs, t your employer or schools for verification of treatment completed, to your personal representative regarding p treatment care as designated by you on our consent form. Your signature will also give us permission to cont you for appointment reminders by mail, fax, at your home, work and voice mail messages on answering machines which could include reminders for any pre-treatment reminders for these appointments.

You may revoke this consent/authorization in writing only on the space provided below and your revocation will not affect any use or disclosures permitted by you while this document is in effect. We would not use or disclose your information listed below for any reason without a second release signature by you.

We attempted to obtain the written acknowledgment on our Notice of Privacy Practices, but the acknowledgment coul not be obtained because:

___ Individual refused to sign ___ Communication barriers prohibited obtaining

___ An emergency situation prevented us from obtaining this acknowledgment

___ Other (Please Specify) _____

Initials of team member _____

CHARLES STANFIELD D.D.S.

Notice of Privacy Practices

Summary Notice Effective April 14, 2003

A new federal regulation called the Health Insurance Portability & Accountability Act (HIPPA) changes the way in which health care companies, medical and dental providers are permitted to use and disclose information about you. Our practice from its inception was and is yet committed to the implementation of policies and procedures to safeguard your information. This summary provides you with the Privacy Practices of this office and briefly states:

* How your health information may be used and disclosed;

* Your rights regarding your health information; and

* Our legal duty to protect the privacy of your health information

You can carefully review the full details of our Privacy Notice Practices in the notebook provided in our reception area following this summary. This summary does not modify or limit the office Detailed Notice of Privacy Practices.

Your Health Information:

Health information is any information we create or receive about you and your past, present or future and may include;

* Physical or mental health or condition * Health care or * Payment for healthcare provided

How We May Use & Disclose Your Health Information:

* Treatment Services * Payment for Services * Health Care Operations

* Your authorization (family/spouse or designated representative * Marketing Health Related Services

* Abuse or Neglect * National Security * Business Associates

* Workers' Compensation * Public Health * Research * When required by law

* Coroner or Funeral Activities * Eligibility for Insurance Benefits & Services

A more detailed description of each of these areas is included in the Notice of Privacy Practices following this summary. All other uses and disclosures of your information will NOT be made without your prior written authorization.

Your Privacy Rights **You have the right to:

* Review your health information * Obtain a copy of your health information * Request information changes/amended

* Request we not use or disclose your information * Request we provide information in an alternative manner/location

* An accounting or list of disclosures of your information * Receive a copy of our Notice of Privacy Practices

Changes We reserve the right to change our Privacy Practice. The revised Privacy Practice would be effective for all health information we already have about you, as well as information we receive in the future. A copy of any revised edition would be available in our reception area and would be designated as a revised edition.

Complaints If you are concerned that your privacy rights have been violated, you may file a complaint to our office or with the Secretary of the U.S. Department of Health and Human Services in Washington DC. We will not take any action against you or in any other way retaliate against you for filing a compliant with us or with the Secretary.