Advanced Dentistry Center
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Bingham Farms, MI 48025
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Suhail Mati, DMD, FAGD

Patient Acknowledgement of Receipt of Notice of Privacy Practices

Patient's Name: _____ Date: ___ /___ /_____
(Please Print)

To comply with the HIPAA requirements, we are giving you a copy of our Notice of Privacy Practices.
I, _____have received a copy of the **Health Information Portability and Accountability Act** (HIPAA Notice) from Dr. Mati's office.

_____

Patient or Guardian Signature Date: ___ /___ /_____

Consent for use of disclosure of Health Information

Michigan Law requires us to obtain a written consent prior to disclosing any of your health information with other collaborating agencies such as your physician, medical doctors, dental and medical laboratories and your dental insurance. You may refuse to sign this consent.*

I, _____(Please Print), consent to the disclosure of my health information which you deem are necessary in connection with my dental treatment.

_____

Patient or Guardian Signature Date: ___ /___ /_____

*For Office Use Only:

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

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify) _____

Office Personnel Initials: _____ Date: ___ /___ /_____