Gerald M. Winkler D.M.D., P.C.
Master Creator Of Healthy Smiles

4 Cabot Place, Suite 8
Stoughton, MA 02072
Phone: (781) 341-WINK (9465)
Fax: (781) 341-9234
contactus@drgeraldmwinkler.com
www.drgeraldmwinkler.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Print Patient Name_____

Patient Date of Birth _____/_____/_____

SECTION B: TO PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND SIGN

Purpose of Consent: By signing this form,, you will consent to our use and disclosure of your protected health information in order to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices **before** you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations and how it effects your protected health information. A copy of the Notice of Privacy Practices accompanies this consent form. Your personal information and dental record have always been handled with the utmost of confidentiality. We are committed to continue our practice in the same manner that allows you to enjoy the highest level of dental care we can provide while protecting your information. We are required by the Federal Law **(HIPPA)** Health Insurance Portability and Accountability Act to share with you just how your information may be disclosed. This is the Reason for reading the **Notice of Privacy Practices** and **signing** this **Consent** form. You are entitled to a copy of this form after you sign it.
As stated in our Notice of Privacy Practices, we reserve the right to change /revise / update our Notice. If changes are made, we will issue a revised Notice reflecting any changes made. You may obtain additional copies of our Notice of Privacy Practices, including any revisions at any time by contacting Gerald M. Winkler, DMD in writing at the address listed above.
Right to Revoke: You have the right to **revoke** this **Consent** at any time by giving us written notice of your revocation submitted to the address of Dr. Gerald M. Winkler noted above. Please understand revocation of this Consent will **not** affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

Signature of Patient / Parent / Guardian / Patient Representative:

I, _____ have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices of Gerald M. Winkler, DMD. I understand by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. Date _____/_____/_____

PLEASE REFER TO BACK PAGE FOR ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

THIS CONSENT FORM MUST BE PLACED IN PATIENT RECORD

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You may refuse to sign this acknowledgment)

I, _____
have received a copy of **Notice of Privacy Practices** for the office of Dr. Gerald M. Winkler.

Print Name _____

Signature _____

Patient / Parent / Guardian / Patient Representative

Date _____/_____/_____

FOR OFFICE USE ONLY

Documentation of Good Faith Efforts

The patient presented to the office of Dr. Gerald M. Winkler on _____/_____/_____ and was provided with a copy of Covered Entity's **Notice of Privacy Practices**. A good faith effort was made to obtain from the patient a written acknowledgement of his/her receipt of the **Notice**.

Such acknowledgment was not obtained for the following reason:

☐ Patient or Parent / Guardian / Patient Representative - **refused to sign**

☐ Communications barriers prohibited obtaining acknowledgement

☐ The patient had an emergency situation which prevented us from obtaining acknowledgement. A second attempt will be made at the next available opportunity.

☐ Other (Please Specify) _____

Name of office personnel completing this section if applicable_____

Signature_____ Date _____/_____/_____

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