Renfroe Family Dental
Derek Renfroe, DMD, FICOI, FAGD
VETERAN OWNED BUSINESS

Dr. Derek Renfroe
311 Spring Street, Dover, TN 37058
931 232 7105, 931 232 2242

Health Insurance Portability and Accountability Act of 1996

HIPAA: Acknowledgment of Receipt of Notice of Privacy Practices

(You may refuse to sign this Acknowledgment)

HIPAA: Consent for Use and Disclosure of Health Information:

(Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign this Consent. Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. Please read this Notice prior to signing this Consent. The practice reserves the right to change the privacy practices as described in our Notice of Privacy Practices. If charges are made, a revised Notice of Privacy Practices containing the modifications will be issued. These changes may apply to any of your protected health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting Connie Peacher, Privacy Office/Office Manager at (931) 232-7105 located at 311 Spring Street, Dover, Tennessee 37058.

You have the right to revoke this Consent for use and Disclosure of Health Information at any time by giving us written notice of your revocation submitted to the Contact Person listed above. This revoke will not affect previous consent. We reserve the right to provide further treatment on your behalf of that of your dependents if this Consent revoked.

I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices. I hereby authorize, as indicated by my signature below, to use an disclose my protected health information to carry out treatment payment activities and healthcare operations.

Signatures below indicate that I have read this entire document fully and understand the contents of this Consent/Authorization/Acknowledgment. I have been provided with the opportunity to ask questions and obtain further clarification.

Patient Name _____ Phone _____ Email _____

_____ _____

SIGNATURE: ○ Patient ○ Parent ○ Guardian ○ Personal Representative Date

Please list the names of individuals you
permit to disclose your protected health information:

1. _____
2. _____
3. _____
4. _____

Please advise us of your preferred means of communication:

☐ You may NOT contact me at work
☐ You may NOT contact me at home or leave messages
☐ You may NOT email or text me over an unsecured network
☐ List your other preference _____