HIPAA RECEIPT OF NOTICE/AUTHORIZATION FORM FOR THE OFFICE OF DR. TODD BAKER

I understand that, under the 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 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 such as quality assessments and physician certifications.

As required by the Privacy Regulation, I am aware that this practice has included a provision that it reserves the right to change the terms of it's notice and to make the new notice provisions effective for all protected health information that it may maintain.

I hereby authorize you to use or disclose the specific information described below, only for the purposes and parties also described below.

YES	NO	
____	____	My name, address, social security number, group number, birth date and employer information to my insurance company/companies for the purpose of reimbursement for treatment rendered.
____	____	May our office/staff call your home and leave a message on your recorder,voice mail or with a family member about an appointment?
____	____	May our office contact you at work to change or confirm an appointment?
____	____	May our office/staff call your place of employment and leave a message about your appointment with a co-worker/voice mail?
____	____	May our office/staff, at your request, call your pharmacy and give your name, birth date and address for prescription/prescriptions?
____	____	May our office/staff give information about your x-rays, treatment, insurance information including birth date and ID # to a specialist such as an Endodontist, Periodontist, Orthodontist, Pedodontist or Oral Surgeon?
____	____	May we contact you by Email ? _____
____	____	May we contact you by Text Message ? Cell Phone #:_____
		May a family member get information about:
____	____	An appointment time/details about an appointment?
____	____	Amount of a bill or an account balance.

If you answered yes to either of the last 2 questions, please list the names of the family members who are allowed to request said information:

Name:_____ DOB:_____
Name:_____ DOB:_____
Name:_____ DOB:_____

If you cannot pick up a prescription from us, can the person/persons listed above, pick up prescriptions for you?_____

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES", and that _____(Staff Member) has answered any questions that I may have had concerning said Privacy Practices to my satisfaction.

DATE:_____PATIENT:(PleasePrint)_____
RELATIONSHIP TO PATIENT:_____SIGNATURE:_____

By signing above, you also agree that you understand that:

- This authorization shall remain in effect from the above date until written withdrawl/or request for change is received by this office.
- That you may inspect or copy the protected health information to be used/disclosed.
- Information used or disclosed pursuant to this authorization may be subject to redislosure by the recipient and no longer protected by this HIPPA AUTHORIZATION.
- You may refuse to sign this authorization and that we will not condition treatment based upon that refusal. (Patient's with insurance coverage, who refuse to sign this authorization should be aware that they will be responsible for full payment of services rendered, on the day of service.)