Caring Smiles
You'll love our care and your smile will show it!

Privacy Policies and Authorization for Information Release

Identity Theft Prevention:

In an effort to prevent identity theft, it is the policy of Caring Smiles to verify all new patient identities at the time of their first visit to the practice. Caring Smiles will, to the extent feasible, request documentation of the patient's identity, residential address and, when appropriate, insurance coverage at the time of initial patient registration. **New Patients are required to bring in a current driver's license or other government issued photo ID and if applicable, a current insurance card**. If the patient's address is different than listed on their ID, a recent utility bill or other statement showing their current address may be used to verify their current address. We appreciate your cooperation and understanding of this policy to help decrease the risk of identity theft.

Acknowledgement of Receipt Notice of Privacy Practices: **You May Refuse to Sign This Acknowledgement**

I have received a copy of the Caring Smiles Notice of Privacy Practices.

Printed Name: _____ **Signature:** _____ **Date:** _____

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communications barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other: _____

Authorization for Release of Protected Health Information: (Optional)

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Email Addresses Where My Information Can Be Sent: _____

Phone Numbers Where My Information Can Be Left on Voicemail: _____

Phone Numbers Where My Information Can Be Sent by Text Message: _____

Person(s) to Receive My Protected Health Information: _____

I understand that I may revoke this authorization at any time by notifying Caring Smiles in writing. If I choose to do so, my revocation will not affect any actions taken by Caring Smiles before receiving my revocation. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Printed Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____