HIPAA

PATIENT CONSENT / ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by John M. Cummins, D.D.S., our staff and our business associates for treatment, payments and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting our office at 630-896-4516 and requesting a revised Notice. We will post any revised notice in the office.

You have the right to request our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care options, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. Finally, you refuse to consent to the use of disclosure of your protected health information, but this must be in writing. Under the law, we have the right to refuse to treat you, should you refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO CONSENT OF THE NOTICE OF PRIVACY.

NAME_____ DATE_____/_____/_____

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE CONSENT / ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

Please list the names and contact information with whom we may discuss your treatment and financial arrangements.

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201 North Constitution Drive Aurora, IL 60506 Phone: 630.896.4516 Fax: 630.896.2180