Jerry M. Rosenberg, DMD
6 Half Acre Rd, Jamesburg, NJ 08831
732-521-4311

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name: _____

Signature: _____

Date: _____

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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 this office's Notice of Privacy Practices. (If not, and you would like one, ask our Front Desk staff and they will be happy to provide you with a copy.)

Print 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 (Please Specify)

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Verification of Identity

Please provide us with the following information.

Name of patient whose information you are requesting: _____

Patient's date of birth: _____

The specific patient information that you are requesting:

_____

Your name: _____

Address: _____

City: _____ State: _____ Zip: _____

Describe your authority to access this information:

_____

If you are a patient's personal representative:

Relationship to Patient_____

I certify that the above information is correct.

Signature: _____ Date: _____

Dental Staff: Describe documentation presented by the requester:

_____

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Request for Confidential Communications

Patient Name (print):_____

Alternative Communication Request (Please tell us the way you would like us to communicate with you, and/or the address you would like us to use):

_____

_____

Payment Information

Your request may affect our normal billing and payment procedure. Please specify your alternative method for handling payment.

_____

_____

Caution: there is some level of risk that third parties might be able to read unencrypted emails.

Signature of Patient: _____Date: _____

For Personal Representatives of the Patient

Print Name of Personal Representative: _____

Relationship to the Patient: _____

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HIPAA Training Sign-in Sheet

Name of Trainer:

_____

Trainer's Company Affiliation: _____

Length of Training: _____Date of Training: _____

Topics Included in Training (attach outline):

_____

_____

Attendee List

Print Name	Signature	Date

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Agreement to Receive Electronic Communication

Patient Name: _____ Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

Dr. Rosenberg's office at **732-521-4311**.

Email Address (PLEASE PRINT CLEARLY):
_____@_____

Patient Signature: _____

Date: _____

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Acknowledgement of Responsibilities Regarding Access to Practice's Electronic Systems Containing Electronic Protected Health Information

Acknowledgement

I, _____, have read and understand that my job assignment grants me clearance to access protected health information (PHI) about individuals and/or their personal representatives. I also have read and understand our practice's policies and procedures on safeguarding PHI, including sanctions that may be imposed against me, regarding the electronic use and disclosure of protected health information.

I further understand that any questions about the security and privacy of protected health information should be addressed to our privacy and/or security official for guidance.

Signature of Employee

JERRY M. ROSENBERG, DMD

Signature of Security Official

Date _____

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Consequences of Unauthorized Access to the Practice's Electronic Protected Health Information

Acknowledgement

I, _____, have read and understand our policies and procedures and sanctions may be applied to me if I abuse the clearance assigned to me.

I also understand that my job responsibilities may change, eliminating my access to protected health information, and if I abuse my privileges and access PHI, even though access has changed, and that the practice has the authority to terminate immediately my employment.
I also understand that if I lose or misplace electronic devices, or if I disable the encryption software safeguarding PHI, enabling an unauthorized user to access protected health information, that I may be subject to legal action taken against me as an individual.

Signature of Employee

JERRY M. ROSENBERG, DMD

Signature of Security Official

Date _____

Jerry M. Rosenberg, DMD
6 Half Acre Rd, Jamesburg, NJ 08831
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Security Incident Report

Description of Attempted or Actual Security Incident:

_____

_____

Date: _____Time: _____Location: _____

Who Discovered Security Incident: _____

How was Security Incident Discovered: _____

Evidence of Incident: _____

Actions Taken to Minimize Damages to Practice's Systems and Electronic Data: _____

_____

_____

_____

Policy and Procedural Changes Implemented to Avoid Recurrence: _____

_____

_____

Security Official Name: Jerry M. Rosenberg, DMD_____

Signature: _____

Date: _____

Jerry M. Rosenberg, DMD
6 Half Acre Rd, Jamesburg, NJ 08831
732-521-4311

Request for Access to Dental Records

Privacy Official Name: Jerry M. Rosenberg, DMD Telephone: 732-521-4311

Patient's Name (Print):_____

Date of Birth: _____ (for identification purposes)

Describe the records you wish to access and the approximate dates of the records:

_____

_____

What would you like for us to do for you?

- ☐ I wish to see the requested records.
- ☐ I wish to get a copy of the requested records.
- ☐ I wish to see and get a copy of the requested records.
- ☐ If the requested records are in an electronic designated record set, I wish an electronic copy of the requested records the following form and format, if readily producible:_____

_____

If you would like the information emailed, enter the email address here (PLEASE PRINT VERY CLEARLY!): _____@_____

We do not recommend sending patient information in an unencrypted email because third parties may be able to access the email.

- ☐ I want you to prepare summary of the requested records and I agree in advance to pay a fee in the amount of $_____.
- ☐ I want you to prepare an explanation of the records that I saw or got a copy of, and
- ☐ I agree in advance to pay a fee in the amount of $_____.
- ☐ I want you to send the copy of the requested records to:

Name: _____
Address: _____

Fees

Our practice charges a reasonable, cost-based fee to for copies of patient information, and for postage to mail records if requested.

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Recibo del Aviso de Prácticas de Privacidad

* Usted puede rehusarse a firmar este acuse de recibo*

He recibido una copia del Aviso de Prácticas de Privacidad de este consultorio.

Nombre en letra de molde: _____
Firma: _____
Fecha: _____

Para uso interno solamente

Intentamos obtener un acuse de recibo por escrito de nuestro Aviso de Prácticas de Privacidad, pero no pudimos obtenerlo por el siguiente motivo:

- ☐ La persona se negó a firmar.
- ☐ Hubo barreras de comunicación que impidieron la obtención del acuse de recibo.
- ☐ Una situación de emergencia nos impidió obtener el acuse de recibo.
- ☐ Otro (especifique)
