Form HP-0942g "HIPAA Privacy Update," ©2024 M.P.

HIPAA PRIVACY UPDATE

Lehigh Valley Smile Designs • Michael A Petrillo DMD PC • Online: www.drpetrillo.com/#privacy
Patrick A.Petrillo, DDS • Bernhard E. Kabitzke, DMD • Phone: 610-868-7601 • Fax: 610-867-8128

HIPAA Privacy Official Contact:
Officer: Michael Petrillo III
Address: 2019 Industrial Drive
Bethlehem, PA 18017
phone: 610.868.9683
email: info@drpetrillo.com

***Patient's Name:** ___________________________________ **Date of Birth:** ____/____/____

Acknowledgement of Notice of Receipt of Privacy Practices

***** You may refuse to sign this acknowledgement *****

This section is 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 received a copy OR read the explanation of this office's Notice of Privacy Practices.

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 ☐ Acknowledgement was prohibited by communication barriers
☐ An emergency prevented us from obtaining acknowledgement (specify): ____

TELEPHONE RELEASE OF PROTECTED INFORMATION

"I authorize you to call my" **work#: (_____) _________________ Ext: ________ other#: (_____) _________________**
home#: (_____) _________________ mobile#: (_____) _________________
"If unable to reach me, you may:" ☐ try CELL# ☐ leave detailed message ☑ Leave me a message asking for a return call.*
The best time to reach me personally is: (day) _____________________ **between (time)** ________ - ________

RELEASE OF PROTECTED INFORMATION

I authorize the release of information including the diagnosis, records (i.e. x-rays); examination rendered to me, billing and claims information. This information may be released to: 1) Myself; 2) ☐ Do not release information to anyone 3) those listed below:

1) Name: ___________________ p#: _______________ Relationship (circle): Self Parent Spouse Child Other: ____________
2) Name: ___________________ p#: _______________ Relationship (circle): Self Parent Spouse Child Other: ____________
3) Name: ___________________ p#: _______________ Relationship (circle): Self Parent Spouse Child Other: ____________

*I do **NOT** authorize any release of information to the following persons(s):* ***NOT*** ***Relationship:***

*I do **NOT** authorize any release of information to the following persons(s):* ***NOT*** ***Relationship:***

AGREEMENT TO RECEIVE ELECTRONIC TRANSMISSION OF INFORMATION (ELECTRONIC COMMUNICATION)

Electronic transmission of information MAY BE DELAYED if not authorized. By signing below,I authorize, consent to and agree to receive any occasional electronic communication (i.e. appointment reminders, forms for signature, x-rays, insurance verification, etc.) and other healthcare messages at my current or future email address on file with the Practice, and/or:

- for appointment via Telemedicine (Interactive Video Communications with an expert provider at a different location from me, a.k.a. "Telehealth," "Video Visits")
- → **at the following updated email address (PLEASE PRINT CLEARLY):** _________________________@___________________
- via encrypted email, secure portal, encrypted cloud drive, direct messaging and/or transmission of access to a portal via a link.
- if I decline to receive encrypted email or portal, I understand the risks if my email provider does not support encryption.
- via SMS text message (i.e. reminders, verify billing) at my cellular phone number on file with the Practice
- I am aware that there is some level of risk that third parties might be able to read unencrypted emails or e-FAX.
- I am responsible for providing the Practice any updates to my email address, fax#, and to save my portal login credentials.
- I can withdraw my consent to electronic communications by calling: (610) 868-7601 or (610) 868-9683

To revoke this authorization: Follow the instructions on this form to call our office, or submit a new form as described in the Notice of Privacy Practices. To the extent that the Practice or its assignees/designees have relied upon your authorization, any withdrawal of consent to send communications and/or files will not impact records that have already been processed, nor any other signed releases. Under 18 requires parent or guardian signature.
***Requests must be specific and in writing. If you cannot be reached regarding identity verification or a pending request, the Practice may attempt to contact you using any method on file and/or rely on your directives, limitations and authorizations in hand.**
*****WE DO NOT RECOMMEND SENDING PATIENT INFORMATION IN UNENCRYPTED EMAIL, BECAUSE THIRD PARTIES MAY BE ABLE TO READ THE EMAIL*****
With my signature, I understand, consent to and agree that "Lehigh Valley Smile Designs" or "Practice" refers to Michael A Petrillo DMD PC, and that:

- **I UNDERSTAND THAT I MAY REFUSE TO SIGN THIS DOCUMENT, AND THAT MY REFUSAL TO SIGN IN NO WAY AFFECTS MY: TREATMENT, PAYMENT, HEALTH PLAN ENROLLMENT, OR ELIGIBILITY OF BENEFITS (EOB).**
- **The Practice has made a good faith effort to obtain my acknowledgement of my receipt of (or an explanation of) their Notice of Privacy Practices.**
- **certain of my contact preferences can also be enabled online, and that the preferences indicated herein may be superseded by any or all of the following actions as authorized and/or signed for digitally by me: Appointment Reminders (i.e. Dental Intelligence Inc., Modento, Dental Sleep Solutions "DS3", Docviaweb, lnc., Virtuox, Inc;) Messeging Preferences; PBHS MySecurePractice (patient portal) Registration/Preferences; my use of Paubox email encryption services or outgoing servers such as via secure reply; use of Dropbox Transfer, Rpost, RMail, RSign, electronic document signing portal, and/or any other of the Practice's HIPAA and/or Release Form(s); or use of service with one of our partners, delegates, assignees and/or Business Associates (i.e. LV Sleep Solutions LLC).**
- **a copy of this authorization or my signature thereon may be used with the same effectiveness as an original, and I also accept my digital signature as valid.**
- **I agree to complete registration/ account creation for the secure portal if I intend to receive copies of requested records; I understand the risks if I refuse.**
- **If I make any request for identifying information in unencrypted format or transmission, I assume all of the risks and I accept the limitations.**
- **"Rpost" indicated above refers to Rpost (by RPost Communications Ltd) and related technologies (electronic signatures; RSign; RForm).**
- **In the event that I decline encrypted email or portal and/or if the secure transmission specified above causes me unexpected delays, I understand the risks if the recipient's email does not support strong encryption and I authorize you to send email message(s), attach to email message(s), as well as to copy/burn information to CD-ROM, or to any standard media.**
- **I understand and assume the risks of any custom request for transfer of my information in an unencrypted email, drive, disk or ANY other custom request.**
- **urgent case presentations, sleep Tests/Surveys, Align Simulations, treatment plans, x-rays, etc. may be sent to me via proprietary portal and/or email.**
- **Michael A Petrillo DMD PC is NOT responsible for encryption-in-motion of information that we receive from other provider(s) (dentist, specialist, etc.)**

Preferences listed above remain in effect until terminated by me in writing. This release of protected information does not expire.

*** Patient Name (Print):** _________________________________ *Relationship:* **SELF PARENT/GAURDIAN REPRESENTATIVE**

*** Patient Signature: X** _________________________________ ***Date:** ____/____/________ **"HIPAA Privacy Update," version HP-0942g.**

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