ALASKA PREMIER DENTAL GROUP

Consent for Use and Disclosure of Health Information (HIPAA)

Alaska Premier Dental Group, LLC, Brian Kruchoski DDS, Joseph Baggette DMD, Clark Bassham DDS - Owners

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of your notice accompanies this consent. **We encourage you to read it carefully and completely before signing**.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, you will be issued a revised Notice of Privacy Practices with all changes.

You may obtain a copy of our Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: ☐ Operations Manager
Telephone: (907)337-1322 Fax: (907)929-2178
Email: akpremierdental100@gci.net
Address: 6611 Debarr Road, Suite 100
Anchorage, AK 99504

Contact Person: ☐ Operations Manager
Telephone: (907)337-0404 Fax: (907)337-6086
Email: akpremierdental@gci.net
Address: 6611 Debarr Road, Suite 200
Anchorage, AK 99504

Contact Person: ☐ Operations Manager
Telephone: (907)373-5930 Fax: (907)373-7702
Email: akpremierdental@mtaonline.net
Address: 865 N. Seward Meridian Parkway, Suite 201
Wasilla, Alaska 99654

I, (name of patient or parent/guardian) _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____
Signature Date

_____ _____
Printed Name (if signed on behalf of patient) Relationship to Patient

This form will be retained in your medical record

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the appropriate APDG office listed on the front page. Please understand that revocation of this consent form will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Revocation of Consent

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of this consent form will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Signature_____ Date: _____

If this Consent is signed by a personal representative on behalf of patient, complete the following:

Personal Representativeôs Name: _____ _____

Relationship to Patient: _____-

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)
- ☐ 6611 Debarr Road, Suite 100
  Anchorage, AK 99504
- ☐ 6611 Debarr Road, Suite 200
  Anchorage, AK 99504
- ☐ 865 N. Seward Meridian Parkway, Suite 201
  Wasilla, Alaska 99654
