HEALTH DEPARTMENT of Northwest Michigan

DCN DENTAL CLINICS NORTH
A PARTNERSHIP OF LOCAL HEALTH DEPARTMENTS

# Consent & Acknowledgement of Receipt of *Notice of Privacy Practices*

I acknowledge that I have been informed of and offered a copy of the Notice of Privacy Practices.

Health Department of Northwest Michigan and Dental Clinics North records and transmits health information, including prescription information, electronically. Health information is shared and protected electronically through local, state and national health information exchanges. This organization participates in the Great Lakes Health Connect (GLHC) information network. GLHC has rules regarding how health information can be accessed through GLHC, and limits on use or disclosures of that information.

Health Department of Northwest Michigan and Dental Clinics North may contact me to provide appointment reminders or information about other health-related benefits and services that may be of interest to me.

I give my permission to Health Department of Northwest Michigan and Dental Clinics North to release my medical information to my medical insurance provider as required for billing purposes. If the service(s) provided are not a covered benefit under my insurance plan or are out-of-network and if I have not met the deductible and/or co-pays, I understand I may be billed for the cost of the service and/or administration fees.

_____
Client's Name (please print)

_____
Signature of client or personal representative Date

_____
If signed by personal representative, relationship to client Date

---

**Office Use Only:**

**If unable to obtain signature, please complete the following:**

A good faith effort was made to obtain the individual's written acknowledgment of receipt of the Notice of Privacy Practices.

Written acknowledgement:

☐ Was not obtained

Reason: _____

Employee Signature _____Date: _____