Acknowledgement of Privacy Practices

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ✓ Provide and coordinate my treatment among a number of healthcare providers who may be involved in the treatment directly or indirectly.
- ✓ Obtain payment from a third-party for my healthcare services.
- ✓ Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information may be used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name_____Date_____

Signature_____

Relationship to Patient_____

I allow the following individuals to have access to my dental records:

_____

_____

_____

For Office Use Only:

We were unable to obtain patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:
The patient refused to sign _____
Communication Barriers _____
Emergency Situation_____
Other:_____