ACKOWLEDGMENT OF PRIVACY PRACTICES

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

- □ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- □ Obtain payment from third-party payers for my health care services
- □ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *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 address above to obtain a current copy of *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is udes or disclosed to carry out treatment, payment or health care 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:_____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

Date: _____ Staff's Initials:_____

We were unable to obtain the 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