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 & 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 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 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 address above 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 is used 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: _____
Dependant family members also covered by this acknowledgement:

_____

Additional Disclosure Authority:
Any member of my immediate family _____ **☐Yes ☐ No**
Spouse only _____ **☐Yes ☐No**
Other (specify) _____ **☐Yes ☐No**

_____

For Office Use Only:
We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ **The patient refused to sign**
- ☐ **Emergency Situation**
- ☐ **Communication Barriers**
- ☐ **Other**