***Acknowledgement of Privacy Practices & Communication Consent Form***

My signature confirms that I have been informed of my rights 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 member of health care providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third party payers for my healthcare services.
* Conduct normal healthcare operations such as quality assessment and improvement.

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 under that my dental provider has the right to change the Notice of Privacy Practices and that I may contact the office at the address above to obtain a 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.

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**Patient or Guardian Signature Date/Time Relationship to Patient**

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**Witness Signature Date/Time**