Ethel Esianor-Mitchual, DDS

West End Medical Condominium
822 Marietta Avenue, Suite 21

HIPPA Notice
Of
Privacy Practices Acknowledgement

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

  ~Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be involved in the treatment directly or indirectly.

  ~Obtain payment from third party payers

  ~Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

- I have received, read, and understood your notice of Privacy Practices containing a more complete description of the used and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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, payments, and my health care operations. I also understand that you are bound by such restrictions.

- I understand that I may revoke this consent at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Accept: _____Yes I accept _____No, I do not accept

Patient/Parent Signature: _____