HIPAA Acknowledgement Form

Patient First Name *

Patient Last Name *

Relationship to the patient *

Name if not the patient *

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

-Obtain payment from designated third-party payers.

-Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practices or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Alexandria Smiles Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Alexandria Smiles Dentistry at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Alexandria Smiles Dentistry restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Alexandria Smiles Dentistry is not required to agree to my requested restrictions, but if Alexandria Smiles Dentistry does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Alexandria Smiles Dentistry has taken action relying on this consent.

By checking the box I acknowledge that *

- [ ] I received and read this organization Notice of Privacy Practices

Please sign *

Clear

Continue

Alexandria Smiles Dentistry