Acknowledgment 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:

1. Provide and coordinate my treatment among a number of health providers who may be involved in that treatment directly and indirectly.

2. Obtain payment from third-party payers for my health care services.

3. 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 received 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. 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 acknowledgment are:

For Office Use Only:

We are unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reasons:

Patient refused to sign _____

Communication barriers _____

Emergency Situation _____ Other _____