ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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 with 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 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.

* * * * * * * *

We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please provide names and numbers of those people who we can share your info with:-

_____

_____

We may use or disclose your information to provide you with appointment reminders (such as voicemail messages, postcards or letters). And we may need to contact you with **CONFIDENTIAL** information regarding your treatment. Where would you prefer we contact you? *Please leave at least one number where we could call or leave you a message.*

HOME : Yes _____ No: _____ Voicemail ok? _____ Number : _____

WORK : Yes _____ No: _____ Voicemail ok? _____ Number : _____

CELL : Yes _____ No: _____ Voicemail ok? _____ Number : _____

Patient Name: _____ Date : _____

Signature: _____

Relationship to Patient: _____