



## 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 (HIPPA). I understand that this form can and will be used to :

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality 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 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 at the address below 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 to such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

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For Office Use Only:

We were unable to obtain the patients written acknowledgement of our Notice due to the following reasons:

\_\_\_ The patient refused to sign

\_\_\_ Communication barriers

\_\_\_ Emergency Situation

\_\_\_ Other

