ACKNOWLEDGEMENT 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 and Accountability Act of 1996 (HIPAA), I understand that this information can and will be used to:

- Provide and coordinated my treatment among 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 provider's **Notice of Privacy Practices** containing a more completed 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 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.

Patient Name:____ Date:____________________

Signature:____

Relationship to Patient:____

Dependent family members also coved by this acknowledgement:

____

Additional Disclosure Authority:
Other? ____Your Signature
Other? ____Their Name/Your Signature
Other-specify ____Their Name/Your Signature