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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Conduct normal healthcare operations such as quality assessment and improvement activities.
- Obtain payment from third-party payers for my health care services.

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 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 healthcare 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: _____

X _____ Date: _____
Signature of patient or parent/guardian if patient is a minor

Relationship to Patient: _____

Office Use: We were unable to obtain the patient's written acknowledgment due to the following reason:
Patient refused to sign _____ Communication Barriers _____ Emergency situation _____