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 (HIPPA). 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
- 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 complete description of the uses and disclosures of my 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 of health care operation, 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: ______________________

Please note dependent family members are also covered by this acknowledgment

---**FOR OFFICE USE** ---

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following:

□ Patient refused to sign

□ Emergency situation

□ Communication barriers

□ Other: ______________________