



Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights of 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.
- 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 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* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy*.

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.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below.

- ANY MEMBER OF MY IMMEDIATE FAMILY** **SPOUSE ONLY:** _____
- Other (please specify):** _____

Patient Name: _____

Date: _____

Signature: _____