



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 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare 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 Practice*. 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 current address 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.

I have read & understand the above

Patient or Guardian Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

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