ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights regarding my protected health information, under the Health Insurance Portability and 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 healthcare providers who may be involved in that treatment directly and indirectly.

*Obtain payment from third-party payers for my health care 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 used and disclosures of my protective 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 health care operations and I understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

Patient Name:_____Date:_____

Signature:_____

Relationship to Patient:_____

Dependant family members also covered by this acknowledgement:

OFFICE USE ONLY:

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

- The patient refused to sign
- Communication barriers
- Emergency situation