ACKNOWLEDGEMENT OF PRIVACY POLICY

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My signature confirms that I have been informed of my rights to privacy regarding my protected 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 had 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 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: _______________________________

Dependent family members also covered by this acknowledgement:

Additional Disclosure Authority
Any member of my immediate family ______________________________ ☐ Yes ☐ No
Spouse only ____ ☐ Yes ☐ No
Other-specify ____ ☐ Yes ☐ No

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For office Use Only:

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

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation
☐ Other