



ACKNOWLEDGEMENT OF RECEIPT OF HIPAA POLICIES AND PROCEDURES

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

I have been informed of my dental providers 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 Practices and that I may contact this office at the provided 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 privacy information is used or disclosed to carry out treatment, payment, or healthcare operations. I also 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 First Name:

Patient Middle Initial:

Patient Last Name:

Patient/Parent/Guardian Signature:

Relationship to Patient: