HIPAA

Acknowledgment of Receipt of Notice Availability of Privacy Policy

Family Dental Health

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and dentist/physician certifications.

I acknowledge that I have received notice of the availability of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time 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 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's Name ______________________________

Signature ______________________________

Relationship ______________________________

Date ______________________________

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of having received notice of the availability of Privacy Policies of this office, but was unable to do so as documented below:

Date ____________ Initials ____________ Reason ______________________________