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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

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

Other uses and disclosures not described in the NPP will be made only with the patient written authorization.

Patient may revoke an authorization at any time, as long as the patient does so in writing, but:

1. If the dental practice has already relied on the authorization to use or disclose patient information the revocation cannot apply to those uses or disclosures
2. If the authorization was for purpose of obtaining insurance coverage, other law gives the insurance company certain rights.

Restricted disclosure to a health plan

1. If a patient asks the dental practice not to disclose information about a health care item or service to a health plan for payment.
2. The dental practice has been paid in full for the item or service by a patient or another on behalf of the patient

I have received, read and understand your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 my treatment, payment or health care operations. I also understand 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 also understand that by signature I am giving my consent to this dental office to send postcards and letters via the mail to the addresses given on my information page in my chart. I understand that these postcards and letters are appointment reminders, statements of accounts, and will contain my address and the address of this dental office.

Patient Name _____ Relationship to Patient _____

Signature _____

Witness _____