

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT & PATIENT CONSENT FORM

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

- Conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in my treatment directly and/or indirectly
- Conduct normal healthcare operations, such as physician certifications and assessments.
- Obtain payment from third party payers, such as insurance companies.
- Confirm and leave messages at phone numbers provided to this office

I have been informed of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. 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 to obtain a current copy of the *Notice of Privacy Practices*

I understand that I may requests in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or dental care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Additional family members
granted access: _____

Signature: _____ Date _____