ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient Name: Birth Date: Date Created

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under *the Health Insurance Portability and Accountability* Act of 1966 (HIPPA*).* I understand that this information can and will be used to:

- ✓ Provide and coordinate 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 health care 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 has 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*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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.

Signature of Patient, Parent or guardian: _____

-For Office Use Only:

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

- The patients refused to sign
- Communication barriers
- Emergency situation
- Other (Please specify):