Notice of Privacy Practice Acknowledgement and Patient Consent Form

I understand, under the Health Insurance Portability and Privacy Act of 1996 (HIPPA). 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 physicians certifications and assessments.
- Obtain payment from third party payers, such as insurance companies.
- Confirm and leave messages and telephone 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 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 request 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 agree to such restrictions.

Patient Name:____

Relationship to Patient:____

Additional Family Members granted access:____

Signature:____Date:________________________