MIKE WHITE DDS

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES & PERMISSION TO DISCUSS DENTAL TREATMENT

DATE:_____

I, the undersigned, acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**. I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions.

*PERMISSION TO DISCUSS DENTAL TREATMENT**

In the event that you may want a family member or friend to discuss your dental treatment with our office, we must have in writing, permission/consent from you to do so.

***Please list <u>any</u> person you give this Dental office permission/consent to discuss your dental treatment and/or finances that go along with your recommended treatment**. If you do not wish to give consent to any person, check the appropriate space below, sign, and date the bottom portion of this form.

PERSON'S NAME:_____ PHONE:_____

PERSON'S NAME:_____ PHONE:_____

□ I hereby give permission/consent to this practice to discuss any and all dental treatment with the above named individuals.

□ I do **not** wish this practice to discuss any of my dental treatment with anyone other than me.

_____ _____

Patient Name (**Please Print**) **Patient *Signature*** (or Personal Representative)

OR _____

Signature of Personal Representative – Authority of Personal Representative to Sign for Patient (*check one*):

□ Parent □ Guardian □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

□ An emergency prevented us from obtaining acknowledgement.

□ A communication barrier prevented us from obtaining acknowledgement.

□ The individual was unwilling to sign. □ Other: _____

_____ _____

Staff Member Signature Date