Town Center Family Dentistry

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability Act of 1996 (herein labeled as HIPPA). I understand that the information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare 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 dental 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 also 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 the practice is not required to agree to my requested restrictions, but if the practice does agree, than it is bound to abide by said restrictions.

Patient Name : _____ Date: _____

Signature : _____

Relationship to Patient: _____

Dependent family members covered by this acknowledgement:

_____

_____

For Office Use Only:

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

- The patient refused to sign
- Communications barriers
- Emergency Situation
- Other : _____