Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 my treatment directly or indirectly.
* Obtain payment from third party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I can contact Paxton Family Dental 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Patient Name** (please print):

**Relationship to Patient:** Self Spouse Parent Guardian

**Patient/Parent/Guardian Signature:**  **Date:**

Authorization To Release Information

Purpose: This is to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, (patient/parent/guardian please print name) , authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

**Note: we cannot speak to your family about your treatment, pain, financials or even give appointment times to others at your request unless their name appears on this form.**

 Please Print First and Last Name. Relationship to Patient

 Please Print First and Last Name. Relationship to Patient

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**BELOW IS FOR OFFICE USE ONLY**

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

 Individual refused to sign. Communication barriers prohibited the acknowledgement.

 An Emergency situation prevented us from obtaining acknowledgement. Other (please specify)