Center Plaza DENTISTRY

x_____
Patient Initial

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Full Name: _____

I understand that, under the Health Insurance Portability and Accountability Act of 1998 (HIPAA), I have certain right 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 for third-party payers
-Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received and read your 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 that I may contact this organization 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.

AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Center Plaza Dentistry dentist and staff is authorized to disclose the following information to the people listed:

Full Name: _____ Relationship:_____
Check all boxes below that apply:
[ ] Dental/Medical health records [ ] Claims and payment [ ] Benefits and coverage [ ] Diagnosis and procedure

Full Name: _____ Relationship:_____
Check all boxes below that apply:
[ ] Dental/Medical health records [ ] Claims and payment [ ] Benefits and coverage [ ] Diagnosis and procedure

Full Name: _____ Relationship:_____
Check all boxes below that apply:
[ ] Dental/Medical health records [ ] Claims and payment [ ] Benefits and coverage [ ] Diagnosis and procedure

By signing below, I certify that all of the above information is true to the best of my knowledge.

Patient/Guardian Signature_____ Date_____

Witness Signature_____ Date_____

Dentist Signature_____ Date_____