

ACKNOWLEDGEMENT and AUTHORIZATION of NOTICE of PRIVACY PRACTICE

In an effort to comply with the Health Insurance Portability and Accountability Act (HIPAA) our office is requesting your acknowledgement and authorization that we are taking reasonable safeguards to protect your confidential health and/or patient information. HIPPA was designed to protect the privacy rights of patients by asking your healthcare provider to disclose minimal private health information (PHI), during treatment and conversations with other dentists, doctors, insurance companies or other parties involved in the your treatment, in any way.

We want our patients to know that we have been following guidelines similar to HIPPA long before it was created. It is now requirement to make a good faith effort to secure our patients acknowledgement and authorization of this law. We have posted our "Notice of Privacy Practice" in our front office where any patient seeking service from us may read it. You may request a copy any time. For more information on HIPPA please go to the Internet or call The Department of Health and Human Services.

Please acknowledge and authorize that you have been informed of, read, or given a copy of our "Notice of Privacy Policies" You may refuse to sign this notice but it will restrict our communications with your other healthcare providers, insurance company, etc.

Print Name _____

Signature _____

Date _____