John M. Schiefelbein DMD, PLLC

Acknowledgement of Notice of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this 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 understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above 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 healthcare operations and I understand that 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 Print Name:_____ Date: _____

Signature:_____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

Additional Disclosure:
Other-specify_____ name/your signature

For Office Use Only

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

- ☐ The patient refused to sign
- ☐ Communications barriers
- ☐ An emergency situation
- ☐ Other (Please Specify)