

ACKNOWLEDGE OF PRIVACY PRACTICES

Premier Periodontics

10050 NE 10<sup>th</sup> Street Ste. C

Bellevue, WA 98004

My signature confirms that I have been informed of my rights of 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 health care 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 health care 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 Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family member also covered by this acknowledgement: \_\_\_\_\_

Additional Disclosure Authority:

Any member of my immediate family \_\_\_\_\_ yes \_\_\_ No \_\_\_

Spouse only \_\_\_\_\_ yes \_\_\_ No \_\_\_

Other-specify \_\_\_\_\_ y es \_\_\_ No \_\_\_