Privacy Practices Acknowledgement

ACKNOWLDGEMENT FORM

The privacy of your medical information is important to us. I have received Notice of Privacy Practices and I have been provided an opportunity to review it.

THE USE AND/OR DISCLOSURE AUTHORIZED

Please list name(s) of persons you authorize for us to disclose and discuss your account and treatment information with our office. (ie: spouse, family relation, legal guardian, etc) or please write not applicable if this does not apply.

ENDING THIS AUTHORIZATION: This authorization does not end until otherwise notified by myself in a written form.

CHANGING YOUR MIND ABOUT THIS AUTHORIZATION: I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, this insurance company has a right to contest my claims under the insurance policy.

SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT: I understand that under most circumstances a dental care provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

POSSIBILITY OF REDISCLOSURE: I understand that information disclosed under this authorization may be redisclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient rediscloses my health information.

INDIVIDUAL PATIENT'S SIGNATURE: I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature: _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: (print name) _____

(Signature) _____