ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Burlington Family Dentistry- Burlington, WA

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 (HIPPA). 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 healthcare 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 healthcare 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 copy of the *Notice of Privacy Practices*. Importantly the updated 09/23/2013 version of the NOPP reflecting the OMNIBUS rule.

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 bond to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)
Names:

_____

_____

For Office Use Only:
We were unable to obtain the patients written acknowledgement of our Notice of Privacy Practice Practices due to the following reason:
__The patient refused to sign
__Communication barriers
__Emergency situation
__Other