NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and I can contact Mountain Bay Dental at any time 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. I also understand 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 (please print):_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Patient/Parent/Guardian Signature:_____ **Date:**_____

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This is to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, (patient/parent/guardian please print name)_____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

***NOTE:** *We cannot speak to your family about your treatment, pain, financials or even give appointment times to others at your request unless their name appears on this form.*

Please Print First and Last Name.	Relationship to Patient
Please Print First and Last Name.	Relationship to Patient
Please Print First and Last Name.	Relationship to Patient

BELOW IS FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

☐ Individual refused to sign. ☐ Communication barriers prohibited the acknowledgement.

☐ An Emergency situation prevented us from obtaining acknowledgement. ☐ Other (please specify)_____