

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Pediatric Dental Center of North Idaho Coeur d'Alene & Sandpoint

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 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 dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 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 agree then you are bound 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.)

OTHER-SPECIFY

Name

Signature

Show ID

-FOR OFFICE USE ONLY:

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

The patient refused to sign Communication barriers Emergency situation Other-