ACKNOWLEDGEMENT OF PRIVACY PRACTICES

ALBRIGHT FAMILY DENTAL
111 SE Everett Mall Way Bldg. D
Everett WA. 98208
425-267-3333 (Phone)

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 health care providers who may be involved in the 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 providers **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 the current copy of **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 of 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: _____

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

OTHER-SPECIFY	Names	Signatures	ID

FOR OFFICE USE ONLY:

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

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other