



**ACKNOWLEDGEMENT OF PRIVACY Notice (HIPPA)**

Updated 2017

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental 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 at the address above 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 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.

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Signature of Patient or patient's representative

Date

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Printed name of patient or patient's representative

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Relationship to the patient

I give permission for the following communications to be used by Capital Dental (**please check all that apply**):

- Cell phone:                       Text Message reminders permitted  
 Home phone                       Work                       E-Mail:

I am granting permission Capital Dental to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Capital Dental to leave a message with any person who may answer my phone or on my voicemail of the following numbers (**please check all that apply**):

- Home Phone     Cell Phone     Work Phone     None- please just ask for a call back  
 Other (Please explain)

**I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:**

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**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 – please list: