ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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 will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or 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 by Kent Station Family Dentistry, of the Notice of Privacy Practices, that contain 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 the Notice of Privacy Practices.

I understand the here at Kent Station Family Dentistry, the doctor may take photos of patients treatment and use them for teaching and identification purposes. These photos are never released or sold to a third party.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

Any Member of my immediate family, Spouse/Partner

Other please specify: _____

Patient Signature: _____ Date: _____

Print Name: _____

Dependents family members also covered by this acknowledgement:

_____ _____ _____

I prefer to be contacted by: (circle all that apply) - Phone – Email – Text

For appointment confirmations, I prefer to be contacted by: TEXT or EMAIL or BOTH

Welcome to Kent Station Family Dentistry