ACKNOWLEDGEMENT OF PRIVACY PRACTICES

MOSES LAKE FAMILY DENTISTRY 975 E. NELSON RD. MOSES LAKE, WA 98837

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 (HIPPA). 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 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 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 our 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.

Patient Name:_____Date:_____

Signature:_____

Relationship to Patient:_____

Dependent family members also covered by this acknowledgement:

_____

Please List any other parties who can have access to your health information:

Name_____Relationship_____

Name_____Relationship_____