ACKNOWLEDGEMENT OF PRIVACY PRACTICES

3700 Fairbanks Ave. Ste. 200
Yakima, WA 98902

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:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers for my health care services
3. Conduct Normal health care operations such as quality assessment and improvement activities
4. I agree to digital communication including Text Messages and Emails at my carrier's standard rate.

To opt OUT of digital communication please initial here:_____

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 Practice;* including the updated 9/23/2013 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 that 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	Names	Signature	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:

□ Patient refused to sign
□ Communication barriers
□ Emergency situation
□ Other