**Authorization:**

 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 that treatment directly and indirectly. Obtain payment form a third-party payers for my health care services and conduct normal health care services and conduct normal health care operations such as quality assessment and improvement activities.

**Notification:**

 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 any dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of Notice of Privacy Practices. I understand that I may request in writing how you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations and 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. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations. Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilitarian review. For example, we disclose treatment information when billing a dental plan for your dental services. Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

**Your Rights:**

 You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, others relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of protected health from us by alternative means or at alternative locations.

The right to access, inspect and copy your protected health information.

The right to request and amendment to your protected health information.

The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

The right to obtain a paper copy of this notice from us upon request.

**Submit:**

 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 a such Notice of Privacy Practices. I understand that any 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 Notice of Private Practices.

Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_