Pediatric Dentistry of Spartanburg

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I understand certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of privacy practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.* (HIPAA) See Below.

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. I also understand 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 _____

Parent/ Guardian Name _____

Relationship to Patient _____

Parent/ Guardian Signature_____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date_____ Initials _____ Reason _____