2025 HIPAA Form

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 can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare 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 descriptive 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 my 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 the Notice of Privacy Practice.

I understand that I may request in writing that this office restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations and I understand that this office is not required to agree to my requested restrictions, but if it is agreed upon, then this office is bound to abide by such restrictions.

May we discuss your medical information/treatment with any member of your family/friends?

☐ YES ☐ NO

If YES, please put their first and last name below with the relationship to you. If No, please write "none".

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What are we allowed to share with them?

☐ All ☐ Appointment Related Only ☐ Financials Only ☐ Other

If other, please specify here

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Patient Full Name

-

Who is signing

-

If "Other" specify who

-

Patient/Legal Guardian Signature (ESign)

Date :

Date

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