WILBUR FAMILY DENTISTRY
DANIEL B. FENN, D.D.S.

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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 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 completed 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 to obtain a current copy of the Notice of Privacy Practices. Importantly the updated 9-23-2013 version of the NOPP reflecting the ONMIBUS 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, 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 are also covered by this acknowledgement

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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 NOPP due to the following reason:

The patient refused to sign *Communication Barriers* *Emergency Situation* *Other*