



DR. GRAHAM GARDNER
Orthodontist

ACKNOWLEDGMENT 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 (including taking photographs, x-rays and models before, during and after treatment)
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement

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 provided address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment, or health care operations. I also 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 also covered by this acknowledgment:

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our *Notice of Privacy Practices* due to the following reason:

- | | |
|-----------------------------------|------------------------------|
| _____ The patient refused to sign | _____ Communication barriers |
| _____ Emergency Situation | _____ Other |