ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Burlingame Dental Arts
7471 SW Barbur Blvd
Portland Or 97219
(503) 246-8447

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the *Health 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 a 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 providersô *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 address above to obtain a current copy of the *Notice of Privacy Practices*.

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 also covered by this acknowledgement:

_____

_____

_____

For office use only:
We were unable to obtain the patientôs written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency Situation
- ☐ Other