Beechwold Dental Care
Notice of Privacy Practices Acknowledgement

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who maybe 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 have received, read and understand 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*.

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.

Name _____

Signature _____ **Date** _____

I am: ◯ The patient ◯ The patient's legal guardian

◯ I give permission for Beechwold Dental Care to leave voicemails concerning my treatment on the phone number(s) I provided

◯ I do not give permission for Beechwold Dental Care to leave voicemails concerning my treatment on the phone number(s) I provided

In case of an emergency, I authorize Beechwold Dental Care to contact and discuss my situation with:

Name _____ **Phone Number**:_____

OFFICE USE ONLY
I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below.

Reason: Date: Initials: