NOVA Dental Anesthesia

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 few healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment form 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 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 healthcare 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(print): _____ Date: ____/_____/_____

Signature: _____

Print Name(parent/guardian): _____

Dependent family member also covered by this acknowledgement:

_____

Relationship to Patient: _____