

# Valley View Dental

## Acknowledgement of Privacy Practices

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that my 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 (insurance companies, collection service agencies, etc.),
- 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 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 below 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.

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**I authorize the doctors and team members at Valley View Dental to discuss my treatment and/or account information with the following person(s): (ie: spouse, parent, adult child)**

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

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