Sandpiper Dental

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2014

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

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 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.

Patients Name: _____ **Date:**_____

I give permission for the following communications to be used by Sandpiper Dental:

☐ Cell phone ☐ Text Message reminders permitted

☐ Home phone ☐ Work ☐ E-Mail:

I give permission for Sandpiper Dental to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N

I grant permission for Sandpiper Dental to leave a message on:

☐ Home phone ☐ Work Phone

☐ Cell Phone ☐ With any person who may answer when calling the home or cell phone

☐ None of the above (Please explain)

I would like the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing.

Name(s): _____

Relation to patient: _____

Signature of patient (parent/guardian): _____Date: _____

Parent/Guardian name: _____