Metropolitan Smiles Family Dentistry

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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.

Name: _____ **Date:** _____

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER(PLEASE EXPLAIN) _____

Please list any dependent children under the age of 18 also covered by this acknowledgement:

_____

I give permission for the following communications to be used by Metropolitan Smiles Family Dentistry PC:

☐ Cell phone: ☐ Text Message reminders permitted
☐ Home phone ☐ Work ☐ E-Mail:

I give permission for Metropolitan Smiles Family Dentistry PC to disclose their identity when calling; to anyone who may answer my phone. ☐Y ☐N ☐ Other (Please explain) _____

I grant permission for Metropolitan Smiles Family Dentistry PC 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 my personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above: _____

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Emergency situation ☐
☐ Communication barriers ☐ Other – please list: _____