HOLLYTREE
DENTAL

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 and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be 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 acknowledge that I have received 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 Notices 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.

PATIENT ACCESS

Please include below any person(s) who is allowed access to your records and appointment information. For underage patients, please include individuals who are permitted to bring them to their appointments and receive their treatment and financial/insurance estimates.The person completing this form will be automatically permitted to obtain all information.

Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name (printed)_____

Patient/Guardian Signature _____ **Date** _____