DIBBLE FAMILY DENTAL

ACKNOWLEDGMENT OF PRIVACY PRACTICES

Dr. Pat and Amanda Dibble
33801 1st Way S, Suite 201
Federal Way, WA 98003

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 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
- 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 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 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 _____ DATE _____

SIGNATURE (PATIENT OR PARENT OF MINOR) _____

DEPENDENT FAMILY MEMBERS ALSO COVERED BY THIS ACKNOWLEDGMENT (LIST ALL THAT APPLY):

FOR OFFICE USE ONLY

We are unable to obtain the patient's written acknowledgment of out Notice of Privacy Practices due to the following reasons:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other