

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES**

**Dr. Henager & Dr. Black
8400 Gage Boulevard
Kennewick, WA 99336**

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 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.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

AUTHORIZATION TO SHARE PRIVATE HEALTH INFORMATION: In order for this office to share any of your private information with any person we must obtain the first and last names of whom we are permitted to share information with and exactly what type of information you wish to be shared. Remember to include friends, spouses, and children – We will not share information with anyone who is not authorized by you.

I _____ Permit this office to share my private information with the following people:

Type of information this office is permitted to share:

- Account information
- Information regarding dental treatment
- Appointments: date, time, and procedure
- Oral health issues
- All of the above

*Note: This authorization will only be given to adults over the age of 18. Information regarding minors will be shared only with their parents/legal guardians or persons who are in charge of the account.