



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 have received, read and understand the Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact the organization at any time at the address below 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 and disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requested restrictions and if you agree then you are bound to abide by such restrictions.

Patient's (or Legal Guardian's) Name Date

Patient's (or Legal Guardian's) Signature Date

Relationship to Patient if Guardian

I understand disclosure may be made to family and friends related to health or as needed for payment of dental services. It has been explained that we only disclose information that is relevant to current treatment. I request that health care information may be disclosed (in person, by phone or email) to:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Patient's (or Legal Guardian's) Signature Date

For up to date Notice of Privacy Policy write to:
Commonwealth Dentistry
Attention: Ginger Grizzard, RDH
2373 Colony Crossing Place
Midlothian, Virginia 23112