ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Northwest Family Dental Care 27081 185TH Ave S.E. Covington, Washington 98042

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 by **Northwest Family Dental Care**, of the Notice of Privacy Practices, that contain 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 **Northwest Family Dental Care** 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.

Here at **Northwest Family Dental Care** the doctors and staff take digital photographs of patients for identification purposes and documentation of procedures. Photos may also be used for teaching and representation to train other staff and patients. These photos are never sold to a third party and no personal details (i.e. name or address) are ever accessible to the public. If you do not fully understand any of the above, please ask.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient (if under 18): _____

Dependent family members also covered by this acknowledgement:

_____

_____

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below:

(Check one)

- ❑ Any member of the immediate family
- ❑ Spouse/Partner only
- ❑ Other (please specify)_____