ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

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Burleson, TX 76028
817-295-3070

My signature confirms that I have been informed of my rights to privacy regarding protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and Texas HB300.

- ☞ 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 health provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the above address 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 care 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:_____

Minor Dependent family members also covered by this acknowledgement (17 and under):

I authorize Alsbury Dental and Staff to discuss treatment plans, payment plans, and treatment rendered to the following:

_____**Spouse** _____ **Family** _____**Referring Specialists**

_____**Other:**_____

I give permission for any correspondences from Alsbury Dental via standard email (xrays, records, referrals to specialist, etc) to be sent through an unsecured website. X_____