kenner dental group
COSMETIC AND RESTORATIVE DENTISTRY

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Acknowledgment of Receipt of Privacy Practices

My signature conforms 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 providers 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 agree then you are bound to abide by such restrictions.

DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
SPOUSE/PARTNER: *PLEASE SPECIFY NAME:*	☐	YES	☐	NO
IMMEDIATE FAMILY: ☐ *MOTHER,* ☐ *FATHER,* ☐ *SIBLINGS,* ☐ *CHILDREN* *PLEASE SPECIFY NAME(S):*	☐	YES	☐	NO
OTHER: *PLEASE SPECIFY NAME(S):*	☐	YES	☐	NO

Name of Patient _____ **Signature of Patient or Guardian** _____

Date _____ **if Guardian, relationship to Patient** _____