ACKNOWLEDGEMENT FORM
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Summary:
By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1.) The right to inspect and copy your information;
2.) The right to request corrections to your information;
3.) The right to request that your information be restricted;
4.) The right to request confidential communication;
5.) The right to a report of disclosures of your information; and
6.) The right to a paper copy of the Notice.

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will insure that your information remains private.
If you have any questions about the Notice, the name and phone number of our contact person is listed on the page of the ***NOTICE OF PRIVACY PRACTICES*** form.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's ***NOTICE OF PRIVACY PRACTICES***. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed on the last page of the ***NOTICE OF PRIVACY PRACTICES*** form. I further understand that the practice will offer me updates to the ***NOTICE OF PRIVACY PRACTICES*** should it be amended, modified, or changed in any way.

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Patient Signature * **Print Patient Name** **Date** *

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Guardian Signature (If applicable) * Print Guardian Name Date *

☐ Patient refused to sign ☐ Patient was unable to sign because ______________________________

HIPAA Privacy Authorization

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 add 164)

1. Authorization

I authorize Rochester Family Dental to use and disclose the protected health information to ____

Relationship to patient: ____

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ ____________ to ____________

** OR **

b. ☐ all past, present, and future periods.

3. This authorization shall be in force and effect until (date or event), ________________________ at which time this authorization expires.

4. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

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Patient Signature* **Print Patient Name** **Date** *

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Guardian Signature (If applicable) * Print Guardian Name Date *

***If completing for digitally and emailing to us, you will be asked to sign and date when you arrive at your appointment. Please leave the above fields for signature and date BLANK.**