DOUGLAS B. GIBBONS, D.D.S, P.C.

ACKNOWLEDGEMENT OF PRIVACY RIGHTS

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. (HIPPA). 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 or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessments and improvement activities.

I have been informed of my dental provider's *Notice of privacy Practices* containing a more complete description of the issues and disclosures of my protected health information. I have been given the right to review 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 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 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 do agree then you are bound to abide by such restrictions.

Print Patient Name: _____Date_____

Signature _____Date_____

Relationship to Patient: Self _____ Dependent _____

Please list all dependents family members also covered by this acknowledgement:

☐_____

_____

_____