Dental Partners of Newburyport
194 High Street
Newburyport, MA 01950
978-465-5358
www.dentalpartnersofnewburyport.com

Acknowledgement of Privacy Practices

My signature below 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 within this office and possibly among a number of health care providers directly and/or indirectly
- Obtain payment from third-party payers (insurance) 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 receive and review 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 do agree you are bound to abide by such restrictions.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

Dependent Family Members also covered by this acknowledgement:

_____

_____

For Office Use only:

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* because:

☐ The patient refused to sign ☐ Communication Barriers

☐ Emergency Situation ☐ Other:_____

ACKNOWLEDGEMENT of PRIVACY PRACTICES