Brett Clifton, DDS

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HIPAA (Health Insurance Portability & Accountability Act)

Notice of Privacy Practices Acknowledgement

Patient Name: ____

Patient Address: ____

Patient Phone Number: ____

I understand that under the HIPAA Act of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. However, we will not be able to release your information to your insurance company without a signature. In that event, we will provide you with a bill at the time of service with your dental codes after your payment in full for you to file with your insurance claim for reimbursement.

Please list individuals that you authorize us to disclose your information to:___________________________________

I acknowledge that I have read your Notice of Privacy Practices and I have a right to request a copy if needed. I understand that Dr. Clifton has the right to change this Notice of Privacy Practices from time to time and that I may contact Dr. Clifton at any time at the address above to obtain a current copy of any changes.

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 healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by those restrictions.

I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

DATED: ______________ PRINTED NAME: ____________________________ SIGNATURE: ___________________________

If you are signing as a personal representative or legal guardian of the patient, describe your relationship to the patient and the source of your authority to sign this form:

RELATIONSHIP: _____________________________ PRINTED NAME: ____