



HIPAA NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT & CONSENT

Patient Name: _____ Date of Birth: _____

Our dental office is committed to protecting the privacy of your protected health information (PHI). Federal law requires us to provide a Notice of Privacy Practices describing how your information may be used and disclosed.

I acknowledge that I have received or been offered a copy of the Notice of Privacy Practices.

Consent

I consent to the use and disclosure of my protected health information for treatment, payment, and healthcare operations, including appointment reminders and insurance processing.

I consent to the use and disclosure of my protected health information.

Communication Preferences (optional)

Phone Voicemail Text Email

Preferred Contact: _____

Authorization to Discuss Information (optional)

Name: _____ Relationship: _____

Patient / Parent / Guardian Signature: _____ Date: _____

Office Use Only (if acknowledgment refused)

Reason: _____ Staff Initials: _____ Date: _____