Redmond Family Smiles
Navid Farzadfar DDS

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

My signature confirms that I am aware 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 among a number of health care providers who may be involved in that treatment directly and indirectly

- € Obtain payment from third-party payers for my health care services

- € Conduct normal health care operations such as quality assessment and improvement activities

Redmond Family Smiles will provide a *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information should I request it. I have been given the right to review and receive 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* at any time.

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 restriction, but if you do agree then 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 acknowledgment of our *Notice of Privacy Practices* due to the following reason(s):

- € The patient refused to sign
- € Communication barriers
- € Emergency situation
- € Other