SEATTLE
SPECIAL CARE DENTISTRY

ACKNOWLEDGEMENT OF PRIVACY POLICY

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 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among other 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

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 review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider had the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below to obtain a 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.

Patient Name:____**Date:**____________________________

Signature:_____________________________________**Relationship to Patient**: ___________________________

Dependent family members also covered by this acknowledgement: ______________________________________

PATIENT COMMUNICATION PREFERENCES

Method	Phone number / Email address	
Home Phone		OK to leave detailed message? ◯ **Y / N** ◯
Cell Phone		OK to leave detailed message? ◯ **Y / N** ◯
Email		◯ **Encrypted / Un-encrypted *** ◯
*In order to read the encrypted message, you will need to enter a password or register for an account with the encryption service.		

Other than your insurance & health providers involved in your care, who can we talk to about your health care?

Name **Contact Info:**

□ Spouse ____

□ Parent ____

□ Other (specify) ____

□ Other (specify) ____

(e.g.: Relative, Caretaker, Group Home, Trust Administrator, Legal Guardian, POA)

By initialing here_________, I give permission to leave medical information pertaining to me, or my dependent, at the contacts listed above. I assume responsibility to inform the practice of changes in my contact information and to give written documentation to revoke previously given authorization.

Please initial to confirm you have read our OFFICE POLICIES. __________