**Barbara J. Utermark, D.M.D., P.C.**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

- *** Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider's who may be involved in that treatment directly and indirectly.**
- *** Obtain payment from third party payers.**
- *** Conduct normal healthcare operations such as quality assurance and dental chart reviews.**

**We ask that you please read the current Notice of Privacy Practices for PHI located in the front office before signing this consent or you may request a copy from the receptionist. There may be periodic changes in the terms of this Notice. You may request a revised copy of the Privacy Notice from our Privacy Officer.**

**It is your right to request that our office restrict how PHI is used or disclosed to fulfill treatment, payment, or health care operations. This practice is not required to agree to these restrictions, however if the Practice agrees to your requested restrictions, the restriction is binding on it.**

**Your information is protected under Federal Law and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (determined by our Privacy Officer). By signing below, you recognize that the protected health information used or disclosed prior to this Consent may be subject to re-disclosure by the recipient and may no longer be protected under Federal Law.**

**Please list below name, relationship, and phone number of individuals that we may communicate with regarding this patients PHI (Protected Health Information).**

| | **NAME** | **RELATIONSHIP** | **PHONE NUMBER** |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |

_____ _____

Parent or Legal Guardian Signature Date

**I have the authority to act for the patient because I am the patient's _____ and have read this Privacy Notice.**

**Patient Name: _____**

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

**[ ] Individual refused to sign**
**[ ] Communications barriers prohibited obtaining the acknowledgment**
**[ ] An emergency situation prevented us from obtaining acknowledgment**
**[ ] Other (Please Specify):**

_____