

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA's requirements, we are giving you a copy of our *Notice of Privacy Practices*. This *Notice of Privacy Practices* contains the information that HIPAA requires us to disclose regarding our privacy practices.

**PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF OUR
NOTICE OF PRIVACY PRACTICES.**

PATIENT ACKNOWLEDGMENT

I acknowledge that I have today received a copy of the *Notice of Privacy Practices*.

Patient Name (please print)

Patient/ Parent Signature

Date

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other healthcare professional. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

**PLEASE SIGN BELOW TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT
IS DEEMED NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT**

PATIENT CONSENT

I consent to your disclosure of my information, which you deem necessary in connection with my treatment. I understand that such disclosure may not be of the type listed.

Patient Name (please print)

Patient/ Parent Signature

Date

May we post a picture of your child on our "NO CAVITY WALL"

YES _____ NO _____ Parent Signature _____