ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Denali Family Dental Center
Dr. David Maisey DDS

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under HIPAA. This information will be utilized solely for the rendering of dental treatment, associated activities and other related health care operations.

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 has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my confidential 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: _____

- o Check here if your consent is being given on behalf of a minor family members or individuals otherwise unable to complete this form.

Minor name: _____

For Office Use Only

An attempt to obtain written acknowledge of receipt of our Privacy Practice was made, however, acknowledgment could not be obtained:

- o Individual refused to sign
- o Communication barriers prohibited us from obtaining the acknowledgment
- o An emergency situation prevented us from obtaining acknowledgement
- o Other(Please Specify)_____
