

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my right privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1. Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly
2. Obtain payment from third-party payers for my health care services
3. 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 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 private information is used disclosed to carry out treatment, payment of 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.

1. Pursuant to Virginia Law 32.1-45.1- Any patient who exposes health care provider of his employee/agent to body fluid in a manner which may transmit the human immunodeficiency virus (HIV), Hepatitis B or C virus is deemed to have consented to HIV, Hepatitis Band C testing and provider who exposes a patient to body fluid in the above stated manner.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement: \_\_\_\_\_

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For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other: \_\_\_\_\_