Rocket City Kids Pediatric Dentistry
HIPPA Acknowledgement Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the updated final rule of 2013. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that secure electronic communication methods will be used regarding my protected health information.

I understand that I have the right to request retractions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I understand that I have the right to opt out of this agreement by refusing to sign this acknowledgement.

Print Patient Name: _____Date: _____

Signature: _____ Relationship to patient: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of our Notice of Privacy policy from this patient.
However, it could not be obtained because: 1. The patient, parent or guardian refused to sign.

2. We were not able to communicate with the patient.

3. Due to an emergency, it was not possible to obtain acknowledgement.

Employee Signature: _____