Acknowledgement of Privacy Practices

Kimberly A. Chapman DDS PLLC

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment, directly or indirectly.

- Obtain payment from third-party payors (insurance) for my services.

- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my healthcare provider's *Notice of Privacy Practices (NPP)* 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 *NPP*. I understand my healthcare provider has the right to change the *NPP,* and that I may contact this office at the address above to obtain a current copy of the *NPP,* including the updated 9-23-13 version reflecting the Omnibus Rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation and I understand that Dr. Chapman's office is not required to agree to my requested restrictions. But if Dr. Chapman's office does agree, then it is bound to abide by such restrictions. This means if you want us to perform treatment that you do ***not*** wish to have reported to your insurance plan, you may request that we do not share that information with them.

Signature _____ Date: _____

Patient Name (printed) _____ Relationship:_____

Special disclosure Authorizations or Restrictions

Name:	Allowed or Prohibited:	Relationship:

For Office Use Only : We were unable to obtain patient's written acknowledgement of our NPP due to (circle)
Refusal to Sign Communication Barrier Emergency Situation