

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

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(206) 623-7296

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Profitability & Accountability Act 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 and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental providers *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* and that I may contact this office at the address above 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 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.

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

- Parent  Guardian  Power of Attorney  Other: \_\_\_\_\_

**Please Note: It is your right to refuse to sign this Acknowledgement.**

*Dental Office Use Only*

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- \_\_\_ An emergency prevented us from obtaining acknowledgement.
- \_\_\_ A communication barrier prevented us from obtaining acknowledgement.
- \_\_\_ The individual was unwilling to sign.
- \_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Staff Member Signature

\_\_\_\_\_  
Date