

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

GLOUSE FAMILY DENTISTRY
800 EAST CLEVELAND AVE.
MONETT, MO 65708

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and doctor certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 healthcare operations. I also understand 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 hereby authorize Glouse Family Dentistry and staff to release any dental, medical, financial information to the following:

1. _____
2. _____
3. _____

Patient's Name: _____

Signature: _____ Relationship to Patient: _____

Date: _____