Acknowledgement of Receipt of Notice of Privacy Practices

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). I understand that by signing this consent, I authorize ASK Dental Care to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatments)
- Obtaining payment from third party payers (ex: my insurance company)
- The day-to-day healthcare operations of ASK Dental Care

I have also been informed of and given the right to review and secure a copy of ASK Dental Care's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that ASK Dental Care reserve the right to change the terms of this notice from time to time and that I may contact ASK Dental Care to obtain the most current copy of this notice.

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

____

Patient Printed Name

____ ______________________________

Signature of Patient **Date**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refuse to sign

_____ Other:

____
____
____

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