Patient HIPAA Acknowledgment Form

Use & Disclosure of Protected Health Information (PHI)

Patient Name:_____ **Date of Birth:**_____/_____/_____

Paga Family Dentistry, PLC "Notice of Privacy Practices" provides information about how we may use and disclose protected health information (PHI) about you. Please acknowledge review and receipt, if requested, of this office's **Notice of Privacy Practices** by ***initialing***:

_____(Patient/Legal Guardian)

Our **Notice of Privacy Practices** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy, if requested, at your next appointment.

_____(Patient/Legal Guardian)

You have the right to request restrictions on how your PHI may be used or disclosed for treatment, payment and health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____(Patient/Legal Guardian)

I authorize **Paga Family Dentistry, PLC** to leave message(s) on the phone number(s) I have provided on the Patient Registration form.

_____(Patient/Legal Guardian)

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Paga Family Dentistry, PLC is authorized to discuss my medical/dental health and treatment with:

_____

Name and Relationship to Individual(s) - if no one, state 'No One'.

_____

Name and Relationship to Individual

Signature of Patient/Legal Guardian:_____ ***Date:***_____

By signing this form, you consent to our use, disclosure and receipt of PHI for treatment, payment and health care operations. Other than activities that have already occurred, you may revoke any further authorizations to use or disclose your health information.