Patient Name: ________________________________

Acknowledgment of Receipt of Notice of Privacy Practices

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

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers and confirm coverage.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Confirm appointments using voicemail, email, text messaging, postcards, or letters.
- Disclose health information to a family member, friend, or caregiver to the extent necessary to help you with your healthcare.

I acknowledge that I have read and/or received the 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 Notices of Privacy Practices from time to time and I may contact this organization at any time 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 information. I also 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, ______________________________, hereby authorized the use or disclosure of my protected health information or of my child/children as described below:

Clark Orthodontics is authorize to disclose health, treatment, and financial information to the following:

________________________________ ________________________________

Name **Relationship to Patient**

________________________________ ________________________________

Name **Relationship to Patient**

________________________________ ________________________________

Name **Relationship to Patient**

________________________________ ________________________________

Name of Parent/Guardian (if under 18) **Relationship to Patient**

________________________________ ________________________________

Signature **Date**