**ACKNOWLEDGEMENT OF PRIVACY PARCTICES**

David T, Doi, D.D.S, Inc.

Holistic Dentistry of Hawaii

64-5191 Kinohou St., Kamuela, Hi. 96743

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the **Health Insurance Probability and Accountability Act** of 1996 (HIPAA). I understand that this is 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 healthcare provider’s *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.* I understand that my health care provider has the right to change the *Notice of Privacy Practices* and I may contact this office at the address above to a current copy of the *Notice of Privacy Practices.* Importantly the updated 9-23-13 version of the **NOPP** reflecting the OMNIBUS rule.

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.

|  |  |
| --- | --- |
| Patient Name: | Date: |
| Signature | |
| Relationship to Patient: | |

**Dependent family members also covered by this acknowledgement:**

Additional Disclosure Authority: (concluded with discussion RE: patient, etc.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Other-Specify | Names | Signatures | ID | ETC |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

For Office use Only:

We were unable to obtain the patient’s written acknowledgement of the *Notice of Privacy Practices* due to the following reason:

\_The patient refused to sign \_ communication barrier \_ Emergency situation \_Other