



HIPAA- PATIENT ACKNOWLEDGMENT FORM

Story City Dental's Notice of Privacy Practices (NOPP) provides information about how we may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that the terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment, and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Story City Dental to leave a message or an email regarding an appointment at:

Home: _____ and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Story City Dental to share medical/dental information with:

1. Name: _____ Relationship: _____

Phone: _____

2. Name: _____ Relationship: _____

Phone: _____

3. Name: _____ Relationship: _____

Phone: _____

I assume responsibility to inform the practice of any changes of the above information.

Patient's Name: _____ Date: _____

Signature of Patient or Legal Guardian: _____