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Notice of Privacy Practices Acknowledgement

Patient Name: _____

Patient Phone Number: _____

I understand that, under the ***Health Insurance Portability & 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 to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *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 *Notice of Privacy Policies* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my practice information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated: _____ **Patient signature:** _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____ **Print Name:** _____

Source of Authority: _____