Apex Oral Surgery

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Acknowledgment of Privacy Practices

My signature confirms I have been informed of my rights to privacy regarding my protected health information (PHI) under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand this information can and will be used for the following:

- Provide and coordinate 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 operation such as quality assessments and improvement activities.
- Electronic communications between Apex Oral surgery and patients as well as electronic communications between Apex Oral Surgery and patient health care providers.

I have been informed the Apex Oral Surgery Notice of Privacy Practices containing a more complete description of the use and disclosures of my protected health information is available at the front desk for copy. I understand Apex Oral Surgery has the right to change the Notice of Privacy Practices and that I may contact this office at the address below to obtain a current copy.

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. 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 of Patient or Guardian: _____

Relationship to Patient: _____

Patient/Guardian Email if electronic communication is desired:

_____

Family members or representatives with permission to access your PHI:

_____

For Office Use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following:

___ Patient refused to sign

___ Communication Barriers

___ Emergency Situation

___ Other