



ORAL AND MAXILLOFACIAL  
SURGERY OF THE LOWCOUNTRY

## ACKNOWLEDGEMENT OF HIPAA

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

- Provide and coordinate my treatment with healthcare providers who may be involved with treatment directly and indirectly.
- Obtain payment from possible third-party payers for services provided.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental 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 dental provider does have the right to change the Notice of Privacy Practices and that I may contact the office at the above address 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 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.

### PROTECTED HEALTH INFORMATION

Protecting your information is very important to us. Please let us know if we have your permission to discuss the contents of your records with any other person(s). Contents may include, but not limited to: health information, social information and account information.

\_\_\_\_\_ NO, Do Not discuss any information with anyone other than myself

\_\_\_\_\_ Yes, You may discuss my information with the following:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

Signature of patient or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

### \*For office use only:

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