NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

DR. JAMIE A. GRIDER

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among any healthcare providers who may be involved in the treatment directly and/or indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I understand your *Notice of Privacy Practices* regarding the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I authorize Legacy Family Dental to release to staff, physicians, hospitals, health care service plans, insurance companies, self-insurers, or their representatives, any and all information, records and x-rays regarding my medical history, services rendered and treatment necessary and obtain any information necessary for treatment.

Patient Name:_____

Signature:_____ Date:_____

If Patient is a Minor:

Name of Legal Guardian: _____ Date:_____

Signature:_____ Relationship to Patient: _____

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