HIPAA – Patient Acknowledgment Form

Our Notice of Privacy Practices (NPP) provides information about how Pure Smiles Hawaii 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 NPP 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 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 healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations. I assume responsibility to inform the practice of any changes in the above information.

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I give permission for Pure Smiles Hawaii to: **(check all that apply)**

_____ Leave voicemail
_____ Text
_____ E-mail _____@_____
_____ Discuss procedures via phone messages, text, or email

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I agree to **share medical and dental information** with these following people:

(1) Name _____ Relationship_____
Phone (_____) _____
(2) Name _____ Relationship_____
Phone (_____) _____

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I have received the Notice of Privacy Practices and have no further questions/concerns regarding HIPAA.

***Signature:»** _____ **Date**: _____

Relationship to patient if patient is a minor: _____

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