Hitchcock Dental

Notice of Privacy Practice

Patient Name: _____ Date of Birth: _____

I have received and understand the Notice of Privacy Practice of Hitchcock Dental. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties information that may be made by this practice, my individual rights and the practice's legal duties with respects to my protected health information. This includes, but not limited to:

- A statement that this practice required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types and uses and disclosures that this practice is permitted to make for each of the following purpose: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use to protect health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of the others uses and disclosures that will be made only with written consent and authorization and that I may exercise the rights in relation to:
    - The right ot complain to this practice and to The Secretary of HHS if I believe my privacy rights have been violated and that no necessary action s will be used against me in the event of such complaint.
    - The right to request restrictions on certain issues and disclosures of my protected health information and that this practice is n ot required to a requested restriction.
    - The right to receive confidential communications of the protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to obtain to receive an accounting of disclosures of the protected information.
    - The right to obtain a paper of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. If changes occur, this practice will provide me a revised Notice of Privacy upon request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):_____