LAKEVILLE ADVANCED DENTAL CARE

HIPAA – PATIENT ACKNOWLEDGEMENT FORM

Lakeville Advanced Dental Care's Notice of Privacy Practices (NOPP) provides information about how we 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 NOPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgment form. In the event that the terms of the Notice change, a revised copy will be make available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for your treatment, payment and office procedures. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or office procedures.

I give permission for Lakeville Advanced Dental Care to leave a voice mail, text message or an email at:

Home: _____ and/or

Cell: _____ and/or

Work: _____ and/or

Email: _____

I give permission for Lakeville Advanced Dental Care to share medical/dental information with:

1. Name: _____ Relationship: _____

   Phone: _____

2. Name: _____ Relationship: _____

   Phone: _____

3. Name: _____ Relationship: _____

   Phone: _____

I assume responsibility to inform the practice of any changes in the above information.

Patient's Name (please print): _____ Date: _____

Signature of Patient or Legal Guardian: _____