⚜ SUGAR LAND ENDODONTICS

Acknowledgement of Notice of Privacy Practices

By signing this form you:

- Acknowledge that we may use or disclose health information to an immediate family member or legal guardian, your general dentist (or a dentist we may refer you to) and your insurance provider to the extent necessary to help with your health care or payment of your health care.
- Acknowledge that you may list any individual that you would like to **NOT** have access to your dental records, and that in listing these individuals; you request that we not give them access to your records, unless instructed by law.
- Acknowledge that you may refuse to sign this form, but that doing so does not void your acknowledgement of your HIPAA rights.

{**Print Name**}_____

{**Signature**}_____ {**Date**} _____

_____

If patient is under 18 years of age

{Parent/Legal Guardian Name} _____

{Signature}_____ {Date}_____

Under HIPPA, we may disclose some information about your account with your insurance provider, your general dentist (or any dentist we may need to refer you to), and your immediate family. (To share your account information with anyone else requires specific written consent). **Is there anyone in this group that you would like *NOT* have access to this information?** (If yes, please list them below):

_____

_____

_____

----------**This section for office use only**----------

We have attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained. Reason for inability to obtain acknowledgement:

- ○ Individual refused/did not want to sign _____ (PATIENT NAME)
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (please specify) _____