Orange Beach Family Dentistry

Lauren H. Lee, DMD

25299 Canal Road Suite A5 - Orange Beach, AL 36561 - 251-321-7575

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the HIPPA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights and 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 the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party providers
- Conduct normal healthcare operations such as quality assessments and physician certifications

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

By signing below, I understand the Privacy Practices of Orange Beach Family Dentistry.

_____ _____

Patient Signature **Date**

I give Orange Beach Family Dentistry permission to share my information

with the following person(s): _____

_____

FOR OFFICE USE ONLY:

Documentation of Failure to Obtain Signed Acknowledgement

Patient Name: _____

- ❑ Individual Refuses to Sign
- ❑ Communication Barriers – prohibited obtaining the acknowledgement
- ❑ Emergency Situation – prevented us from obtaining the acknowledgement
- ❑ Other – please explain: _____

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_____ _____

Staff Signature **Date**