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WILKINSON ORTHODONTICS

David A. Wilkinson, D.D.S., M.S.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding protected information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions. If you agree then you are bound to comply with such restrictions.

AUTHORIZATION FOR USE OF PRIVATE HEALTHCARE INFORMATION

HIPAA'S Privacy Rule requires covered entities (practices that send or receive insurance claims electronically) to obtain signed "authorizations" to use or disclose information beyond treatment, payment or healthcare operations. Your protected health information, including individually identifiable information, such as names, photographs, x-rays and study models, may be used or disclosed for the following purposes in this office:

(Please circle yes or no to optional use of name and/or diagnostic records)

YES NO Lectures and/or Professional Presentations (no use of names)

YES NO Display of names and photographs with our office (contests, contest winners, after treatment portrait, etc.)

YES NO Display of names (first name only) and photographs on our internet sites including our Website, facebook and blog

By signing below I understand all terms listed above.

Patient Name: _____

Responsible Name: _____ Relation to Patient: _____

Signature: _____ Date: _____

For Office Use Only: We were unable to obtain the patients written acknowledgement of our Notice of Privacy due to following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other