

## **HIPAA: Notice of Privacy Practices**

This form is optional under the new patient privacy regulations recently issued by the United States Department of Health & Human Services. We have elected to use this form. Prior to commencing your Dental treatment, you should review, sign and date this form.

Your protected health information & other biographical data may be used in connection with your treatment, payment of your account or health care operations. You have the right to review our office's privacy notice prior to signing this acknowledgement; a copy of which is available upon request.

Patient Name	Date
Signature of Patient/Parent/Guardian	Date
Signature of Fatterity are ity data data	suic
Reason for No Signature	
Authorization for Release of Patient Information	
I hereby authorize the doctor(s) of DentalPros to prove regarding the individual's dental care as deemed app doctor(s) and staff has (have) no responsibility for an information.	ropriate. I understand that once released, the above
Patient Name	_Date_
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Signature of Patient/Parent/Guardian	Date