

Thomasson Dental
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ACKNOWLEDGEMENT

of

Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information.

I have been provided and given the opportunity to read the Office's ***Notice of Privacy Practices***. The notice provides a complete detailed description of the uses and disclosures of my health information.

I understand that I may contact this office at any time to inquire about my private information and how it is being used.

Patient Name: _____

Signature: _____

Date: ____ / ____ / ____