Children's Dental Associates of Hamden-

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

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I understand that, under the Health Insurance Portability and Accountably Act of 1998 (HIPPA) I have certain rights to privacy regarding my protected health information (PHI).

I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and dentist certifications.

I acknowledge that I have received and read your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Relationship to Patient: _____

Sign Here:_____

Dated: _____

FOR OFFICE USE ONLY:

_____ attempted to obtain the patient, patient parent or guardian's signature acknowledging receipt of CDA of Hamden's Notice of Privacy , but was unable to do so as documented below:

Rev:11/2016LDM