Atlantic DENTAL ASSOCIATES

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to 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 payers.
- Conduct normal healthcare operations.

I acknowledge that I may request a copy of Atlantic Dental Associate's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. This organization has the right to change its *Notice of Privacy Practices* from time to time and I may, at any time, obtain a current copy of the *Notice of Privacy Practices*.

I understand that I can request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions; however, if you do agree then you are bound to abide by such restrictions.

I authorize Atlantic Dental Associates to email my radiographs (x-rays) and dental records to other dentists or insurance companies.

In the unlikely event an employee of Atlantic Dental Associates is stuck by a needle or a dental instrument, I authorize Atlantic Dental Associates to release my records to the Brunswick County Department of Health.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason:

Frederick A. Williams, DMD, PA

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