Smile West Seattle

3623 SW Alaska Street

Seattle, WA 98126

Ph (206)453-3006 F (206)453-3008

Acknowledgment of Privacy Practices

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

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

I have been informed of my dental providers *Notice of Privacy Practices* containing a more complete description of the uses and discloses of my protected health information. I have been given the right to review, receive, and copy such a *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 at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Smile West Seattle how my private information is used or disclosed top carry out treatment, payment of health care operations and I understand that Smile West Seattle is not required to agree to my requested restrictions, but if Smile West Seattle does not agree that you are still bound to abide by such restrictions.

Patient Name _____**Date**: _____

Signature_____

For Office Use Only:

We were unable to obtain the patients written acknowledgment of out Notice of Privacy Practice due to the fallowing reason: