



VIRAMONTES SMILE CARE
DENTAL HYGIENE PRACTICE

**HIPAA NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT & CONSENT**

Patient Name: _____ Date: _____

ACKNOWLEDGMENT

I acknowledge that Viramontes Smile Care Dental Hygiene Practice has offered or provided me access to its Notice of Privacy Practices. I understand that the Notice explains how my protected health information (PHI) may be used and disclosed, the practice's legal duties, and my privacy rights.

☐ I received a copy of the Notice.

☐ I was offered a copy and declined.

USE & DISCLOSURE OF HEALTH INFORMATION

I understand that my PHI may be used or disclosed as permitted by law for treatment, payment, and health care operations, and when otherwise required or permitted by law. Uses or disclosures requiring a separate authorization will be handled with an appropriate written authorization.

MY PRIVACY RIGHTS

I understand that, subject to applicable law, I may request access to or copies of my records; request an amendment; request confidential communications; request certain restrictions; and request an accounting of certain disclosures. I may request a paper copy of the Notice of Privacy Practices at any time.

COMMUNICATION PREFERENCES

The practice may contact me about appointments, treatment, billing, insurance, and other practice-related matters using the methods I authorize below:

☐ Phone

☐ Voicemail

☐ Text

☐ Email

☐ Mail

AUTHORIZED PERSON(S) - OPTIONAL

I authorize the practice to discuss my appointments, treatment, billing, or other health information with:

Name: _____

Relationship: _____

Name: _____

Relationship: _____

SIGNATURE

By signing below, I acknowledge that I have read and understand this form, have had an opportunity to ask questions, and have been offered access to the practice's Notice of Privacy Practices.

Patient/Legal Representative Signature: _____

Date: _____

Relationship to Patient (if applicable): _____

FOR PRACTICE USE ONLY - IF ACKNOWLEDGMENT WAS NOT OBTAINED

☐ Patient declined

☐ Emergency

☐ Communication barrier

☐ Other:

Other reason: _____

Clinician Signature: _____ Date: _____

Practice: Viramontes Smile Care Dental Hygiene Practice

This one-page form documents acknowledgment/consent. The practice's full Notice of Privacy Practices should be maintained separately and made available as required.