Acknowledgment of Privacy Practices Notification

Charles and Linda Steel, DDS, PA
605 Olney-Sandy Spring Road
Sandy Spring, MD 20860

My signature below indicated that I have been informed and understand my rights to privacy as it related to protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I also understand and agree that this information can and will be used to :

- Plan, conduct, direct and coordinate my treatment among multiple health care providers, who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care treatment and services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have received, read and understand your Notice of Privacy Practices (also available on our website), containing more detailed description of the use and disclosure of my health information. I understand that my dental care provider has the right to change or modify the Notice of Privacy Practices and I may contact this office at the address noted above to obtain a current copy if I desire.

I understand that I may request in writing that you restrict how my private information is used, shared or disclosed to carry out treatment, payment or health care operations. I also understand that your office is not required to agree with my requested restrictions. But if you agree, you are bound to abide by those restrictions.

Patient Name _____ Date _____

Signature _____

Relationship of signer to Patient _____Date _____

Please note that dependent family members are also covered by this document

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Office Use Only

I attempted, but was unable to obtain the patient's signature of acknowledgement.
Refused to sign Communication barrier Emergency Other (write below)

_____

Date _____ *Name / Initials* _____