

Alane F. Holliday, DDS

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

We use health information about you for treatment, to obtain for treatment, for administrative purposes, and to evaluate the quality of care that you receive. This is a summary of your rights under the **Health Insurance Portability and Accountability Act (HIPAA)**.

In most situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you may later revoke that authorization to stop any future uses and disclosures. We reserve the right to change our policies at any time. Before we make a significant change in our policies, we will post the changes in the waiting area and in each examination room. You may also request a full copy of our **Notice of Privacy Practices** at any time by contacting our office.

Although your dental record is the physical property of your dentist, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- inspect and obtain a copy of your health and dental record
- amend your health and dental record
- obtain an accounting of disclosures of your health and dental information
- request communication of your health and dental information by alternative means or at alternative locations
- revoke your authorization to use or disclose health and dental information, except to the extent that action has already been taken

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You may also send a written complain to the **U.S. Department of Health and Human Services**. Our office can provide you with the appropriate address upon request.

- If you have any questions, please contact our office: 901-754-8080

WRITTEN ACKNOWLEDGEMENT

My signature confirms that I have been advised of my rights under the **Health Insurance Portability and Accountability Act (HIPAA)**. I understand that I may request, in writing, restrictions as to how my health and dental information may be used or disclosed. I understand that you are not required to agree to the restrictions I request, but that if you do agree you are bound to abide by them.

Signature of Patient or Legal Representative

Date

Please list any other family members that we can discuss your information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____