Welcome to Kim K. York, D.D.S., PC Family Dentistry

Acknowledgement of receipt of Notice of Privacy Practices (HIPPA)

You may refuse to sign this acknowledgement

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.

I give this office permission to discuss my treatment or account information with:

_____ Patients listed on my account _____ The Guarantor listed on my account

_____ The following people:

_____ _____

Name Relationship

I have received a copy of this office's Notice of Privacy Practices:

_____

Please Print Patient Name

_____

Signature of Patient or Guardian Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices" but acknowledgement could not be obtained because:

_____ Individual refused to sign _____ Communication barriers prohibited obtaining the acknowledgement _____An emergency situation prevented us from obtaining acknowledgement _____ Other (please specify)