NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), 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.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

*_______ I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Christine Theroux, DDS has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.*

*_______ I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

***(Please initial)**

HIPAA AUTHORIZATION

(Permission from patient/patient’s legal guardian to share personal medical information)

I, __________________________, hereby authorize Christine Theroux, DDS Prof LLC to release any and all
NAME OF PATIENT

medical information that may pertain to me to the following individual(s):

Name: ___________________ Phone #: (______)-_____________ Relationship to Pt: ___________________

Name: ___________________ Phone #: (______)-_____________ Relationship to Pt: ___________________

I authorize Christine Theroux, DDS Prof LLC to contact the individual(s) listed above to convey any pertinent information about me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Christine Theroux, DDS Prof LLC in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is released.

______________________________ Date: ___________________
Signature of Patient

OR, if applicable

______________________________ Date: ___________________
Signature of Legal Guardian