Northwind Dental

3719 E. Meridian Loop Ste. B
Wasilla, AK 99654

HIPAA Acknowledgement

Patient Acknowledgement Form

Your privacy, including the confidentiality of your health information, is very important to us. Additionally, Federal law prohibits the unauthorized release of certain medical and health information. Before our office can use your Protected Health Information for treatment, payment and healthcare operations, you must acknowledge that you have read our Notice of Privacy Practices informing you how our office may use and disclose your Protected Health Information.

You should carefully read our Notice of Privacy Practices to understand how we take steps to protect the privacy and confidentiality of your Protected Health Information. Federal law gives you certain rights regarding the use and disclosure of your Protected Health Information. These rights include: (1) the right to restrict how your Protected Health Information can be used or disclosed for treatment; (2) the right to receive confidential communications of your Protected Health Information, if applicable; (3) the right to inspect and copy your Protected Health Information; (4) the right to amend your Protected Health Information; and (5) the right to receive an accounting of the disclosures of your Protected Health Information.

By signing this form, you acknowledge that you have read our Notice of Privacy Practices concerning the use and disclosure of your Protected Health Information.

I consent to the release of verbal information regarding my diagnosis/treatment plan to:

( ) my spouse ( ) my children ( ) my family members ( ) other _____

( ) I authorize Northwind Dental to leave dental information on my voicemail or answering machine.

_____
Print name of patient

_____ _____
Signature of patient or legal guardian Date