NOTICE OF PRIVACY PRACTICES 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.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of this Notice for full explanation of time and fees involved.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but no before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions. but if we will abide by our agreement (except in an emergency).

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

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

PATIENT NAME:_____RELATIONSHIP TO PATIENT_____

SIGNATURE_____DATE:_____

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns. please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information,you may complain to us using the contact information listed at the end of this Notice.You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint.

Norcross Office: 6000 Singleton Rd Suite 315, Norcross, GA 30093 - **Albany Office:** 1030-A West Gordon Avenue, Albany, GA 31701

Authorization for additional disclosure: I am the "personal representative" of (generally parent or legal guardian) and have legal authority to make health care decisions about the following minor patient:

Patient Name:_____

As the "personal representative" of the above named patient, I authorize the following individuals to accompany my child and have access to health information and make decisions regarding treatment

Name:_____**Relationship**_____

_____ _____

_____ _____

_____ _____

"Personal Representative" (Parent or legal Guardian) **Date**

FOR OFFICE USE ONLY

I have reviewed the patient information form and did not find any discrepancies.

Front Desk initials _____**Date**_____**Hygienist initials**_____**Date** _____ **Dentist initials** _____ **Date**_____