

ACKNOWLEDGEMENT OF  
PRIVACY PRACTICES

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My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers for my health services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of this.

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 that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Patient's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

For office use only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reasons:

*\*Patient refused to sign   \*Communication Barriers   \*Emergency Situation   \*Other*