

MEDICAL ARTS COMPLEX DENTAL CENTER, S.C.

704 S. Webster Avenue • Green Bay, WI / 233 S. Erie Street • De Pere, WI

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 in one or more of the following respects:

- To other health care providers in connection with my treatment.
- To insurance companies, employers with direct reimbursement or administrators of flexible spending account, etc. in order to obtain payment of my account.
- Internally, to all staff members who have any role in my treatment.
- To my family involved in my treatment, with my permission. (Please list below.)
 1. _____
 2. _____
- This office may contact me to provide appointment reminders.

Any other uses of my protected health information will be made only after obtaining my written authorization, which I have the right to revoke.

I acknowledge that I have received and understand your written Notice of Privacy Policy.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

OFFICE USE ONLY:

** Acknowledgement unable to be obtained. Reason: _____

Employee Signature

Date:

Patient Name

Account Number