# HIPAA

## 'Health Insurance Portability and Accountability Act'

## Privacy Policy Acknowledgement

## Pleasant Valley Dentistry

Patient's Name: _____ Date: _____

Patients Date of Birth: _____ SSN: _____

- I verify that the information given on the health history form is true and correct.
- I understand that the office and staff of Pleasant Valley Dentistry will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone number.
- I understand that there may be times when the doctor and staff will need to speak with me regarding an appointment time, a test result or financial arrangements. If I'm not at the number given, they have permission to leave a brief message at my home or work number provided.
- I give my permission to Pleasant Valley Dentistry and staff to correspond with my general physician, or specialist that I'm under care with.
- I understand that my health information will only be given to me or my legal guardian and cannot be given to my spouse or other family members.
- Upon my request, I will be given a full and complete copy of HIPAA privacy policy.
- If there are specific restrictions on use of my personal health information, I will notify Pleasant Valley Dentistry in writing of these restrictions.

_____ _____

Signature of Patient or Guardian Date