

ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Smiles For Kids Pediatric Dentistry
201 N Arlington Heights Rd, Suite 200
Arlington Heights, IL 60004**

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 (HIPAA). I give my consent to the use and disclosure of my child's protected health information and 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 care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my child's 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 child's 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 the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my child's private information is used or disclosed to carry out treatment, payment or health care operations and I 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.

I have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations.

Parent Name: _____ Signature: _____ Date: _____

Dependent children covered by this acknowledgement:

For Office Use Only:

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

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other