



**Hilde Family Dentistry**  
Jason L. Hilde, D.D.S., P.L.L.C.

## Welcome to Hilde Family Dentistry

### Notice of Privacy Practices Acknowledgment

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 to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood 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 to time and that I may contact this organization at any time to obtain a current copy of the **Notice of Privacy Practices**.

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

### Additional Disclosure Authorization

May we discuss your treatment with: (Please check all that apply)

- Entire Immediate Family
- Spouse only
- Other (Please specify) \_\_\_\_\_

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

Relationship to Patient:  Self  Mother  Father  Guardian

Signature \_\_\_\_\_ Date \_\_\_\_\_

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### Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this **Notice of Privacy Practices Acknowledgment**, but was unable to do so as commented below:

Initials \_\_\_\_\_ Reason \_\_\_\_\_