Health Insurance Portability and Accountability Act
(HIPAA ACT)

Privacy Policies Acknowledgement

Patient Name: ___________________________________

Date of Birth: ____________________

I verify that the information given on the Health History form is true and correct.

- I understand that the office staff of DDL Dental will make every reasonable effort to protect my personal health information including my social security number, date of birth, address and phone numbers.
- I understand that there may be times when the Doctor and staff will need to speak with me regarding an appointment time or financial arrangements. If I am not at the numbers given, they have my permission to leave a brief message at my home or work numbers provided.
- I give permission to Doctor and staff to correspond with my general physician or specialists that I am under care with. This includes my insurance provider.
- 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 without written consent.
- If I request, I will be given a full copy of the HIPPA privacy policy.
- If there are specific restrictions on the use of my Personal Health Information, I will notify DDL Dental in writing of these restrictions.

____ ________________
Signature Date

____
Legal Guardian if applicable

I hereby authorize DDL Dental to share my information with

____

Signature

Date