NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT

HIPAA (Health Insurance Portability and Accountability Act)

By signing below, you consent to the use and disclosure of your protected health information by Summercrest Dental's doctors, staff, and business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please ask to see our Notice of Information Practices. You have the right to review our Notice prior to signing this Consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (913) 491-4516 and requesting a revised Notice. We will also post any revised notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your protected health information (PHI).

I have reviewed, understand and agree to the content of the Notice of Privacy.

Name:_____ Date:_____

If patient chooses not to sign the form, please specify reason below:

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If patient chooses to authorize another individual to have access to their health information, they may list the authorized individuals below:

Name	Relationship
Name	Relationship