Swearingen Dental Care
48959 Calcutta Smith Ferry Road
East Liverpool, Ohio 43920
Swearingensmiles.com
330.385.4126

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my "Protected Health Information" (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among 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/dentist certifications.

I have received, read and understand 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 at the above address to obtain a 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 that you are not required to agree with my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient name:

If other than Patient, relationship to Patient:

Signature:

Date:

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize my PHI to be used and disclosed at my request for:

DIAGNOSIS, TREATMENT, REVIEW AND REFERRAL:	[ ]	I understand that by checking this box, I give permission to use my PHI for the purpose of diagnosing, treating, reviewing, and referral.

This assignment will remain in effect until revoked by me in writing.

I understand that I have the right to receive a copy of this authorization. I also understand that I may revoke or modify this authorization at any time by notifying Swearingen Dental in writing. I understand that my revocation or modification of this authorization will not affect any actions taken by Swearingen Dental in reliance on this authorization before Swearingen Dental receives my request for revocation or modification. I must sign my written request and send it to Swearingen Dental at the above address.

Signed: [ ] Patient [ ] Parent [ ] Legal Guardian [ ] Responsible Party	Date:

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Name	Initials	Reason