NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ROSEMARIE MIDDLETON, DDS, MS
18926 FREEPORT DRIVE
MONTGOMERY, TEXAS 77356
936-582-7700 *phone*

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 acknowledge that I may request a copy 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 address above to obtain a current copy of the *Notice of Privacy Practices.*

I, _____, give my authorization to Dr. Rosemarie Middleton to release

in person/phone or email _____ (patient's name) protected health

information pertaining to his/her Orthodontic treatment to the following designated representatives. These

persons may also be accompanying the patient to appointments. (Please mark and fill out where applicable)

☐ **Current Dentist or other health care providers** ☐ My Spouse (name) _____

☐ Step-Parent (name) _____ ☐ My Child (name) _____

☐ Grandparent (name) _____ ☐ other (name) _____

☐ May be left on my voice mail or home answering machine

☐ MAY NOT BE GIVEN TO ANYONE OTHER THAN ME

Patient's Name: _____ Date: _____

Parent/Guardian's Name: _____

Signature: _____

Relationship to Patient: _____

I understand that I may request in writing that you restrict how the private information is used or disclosed to carry out treatment, payment or health care operations, except to the extent that action has been taken in reliance on this authorization or if applicable, during a contestability period. The request must include the patient's name, address, and date of birth, the reason for the restriction, the date of the restriction and the signature of the patient and/or parent/guardian. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.