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## ACKNOWLEDGEMENT OF AWARENESS AND/OR RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

I, (patient) _____, (date of birth _____) have read the "Notice of Privacy Practices (HIPAA)" from Orthodontic Associates.

Patient/Guardian Signature _____Date_____

I authorize my personal dental health information to be disclosed to the following individuals, if necessary. (This is for Family/Caregivers. Treating Doctor names are not needed here)

NAME _____DOB_____RELATIONSHIP_____PHONE_____

NAME _____DOB _____RELATIONSHIP_____PHONE_____

NAME _____DOB _____RELATIONSHIP_____PHONE_____

I authorize permission to contact me with confidential communications about dental care via

- Text # _____ YES NO
- Email _____ YES NO

FOR OFFICE USE ONLY

As a staff member of Orthodontics Associates, the above patient/guardian has been made aware of our current "Notice of Privacy Practices (HIPAA)"

Staff member signature _____date _____