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ORTHODONTIST
BRACES FOR CHILDREN & ADULTS

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HERMISTON
1060 W. Elm, Suite 135
Hermiston, OR 97838
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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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 the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and doctor 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 Vancouver Orthodontic Specialists has the right to change its ***Notices of Privacy Practices*** from time to time and that I may contact them at any time at the address above to obtain a current 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 for health care operations. 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.

Patient Name: ______________________________ Date: ____________

Parent/Legal Guardian (if applicable): ______________________________

Signature: ______________________________

Relationship to Patient: ☐ Self ☐ Parent/Legal Guardian ☐ Other: ____________

I would like to give the following individuals authorization to discuss matters relating to my treatment and account. I understand without this consent, no one, other than myself, will be able to discuss these matters. This authorization will remain in effect until withdrawn by you in writing.

____________ Relationship to Patient: ☐ Spouse ☐ Parent/ Legal Guardian ☐ Other: __________
____________ Relationship to Patient: ☐ Spouse ☐ Parent/ Legal Guardian ☐ Other: __________

OFFICE USE ONLY

I attempted to obtain the patient's or legally authorized individual signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: