Print Form

Acknowledgment of Privacy Practices

New England Dental Group
1600 N. New England Ave.
Chicago, IL 60653

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability of 1996 (HIPAA). I understand this information can and will be used to:

- Provide & coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal health care operations such as quality assessment & improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing specific restrictions on ho my private information is used to carry out treatment, payment, or other health care operations. I understand that you are not required to agree to my requested restrictions, but that if you do agree, then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____

Relationship to patient _____ Dependent family members also

covered by this acknowledgment _____

For official use only:
We are unable to obtain the patient written acknowledgment of our Notice of Privacy Practices.

Pt refusal communication barriers ER situations other, (specify)