KENNETH C. BARNEY, D.D.S.
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ARTISTRY • INTEGRITY • PASSION

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

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 such *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 that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Please list any dependent children under the age of 18 also covered by this acknowledgement:

______________________________ ______________________________
______________________________ ______________________________

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

☐ NO ONE

Name:______________________________Relation to patient:______________

Name:______________________________Relation to patient:______________

Name:______________________________ Relation to patient:______________

☐ I give permission for the following communications to be used by Dr. Kenneth C. Barney DDS, **(please check all that apply)** : ☐Cell phone ☐Home phone ☐ Work ☐ E-mail:________________

☐ I am granting permission for Dr. Kenneth C. Barney, DDS to disclose their identity to anyone who may answer my home, work or cell phone.

☐ I am granting permission for Dr. Kenneth C. Barney, DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back

Signature: ______________________________ ***Date:*** ______________

RELATIONSHIP TO PATIENT: ☐*ADULT PATIENT* ☐*PARENT* ☐*GUARDIAN* ☐*OTHER*________

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation
☐ Other – please list: ______________________________

Patient Name:__________ DOB:__________ Chart:__________