ACKNOWLEDGEMENT OF *NOTICE OF PRIVACY PRACTICES* – HIPAA

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, paper and/or email. I understand that if my child comes with another adult, treatment may be discussed with that person. **I have been offered a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.**

I further understand that North Potomac Orthodontics reserves the right to change their notice and practices in accordance with Section 164.520 and 164.506 of the Code of Federal Regulations.

_____

Please Print Patient's Name

_____

Signature of Patient (OR parent or Guardian)

_____

Date

In Office Use Only

- ☐ Individual refused to sign
- ☐ Communication barrier prevented obtaining the acknowledgement
- ☐ An emergency situation prevented obtaining the acknowledgement