JONES DENTAL CLINIC

HIPPA ACKNOWLEDGEMENT

PATIENT NAME _____

PARENT/GUARDIAN NAME _____
(if applicable)

RELATIONSHIP TO PATIENT _____

I understand that the information that I have given regarding my health history is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes.
I also acknowledge that the full Notice of Privacy Practices is available at Jones Dental Clinic and I am able to view it upon request.

Signed _____Date_____

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting Kim Crawford, Privacy Officer for the office.