Shores Family Dentistry

4360 Boardwalk Drive Suite 100, Fort Collins CO 80525 – Phone: (970) 226-2920

NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGMENT

PATIENT NAME: _____ DATE OF BIRTH: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice include:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to disclose information.
- A description of other uses and disclosers that will be made only with my written authorization, and that I may revoke such authorization.
- My individual rights with respect to protected health information, and a brief description of how I may exercise these rights in relation to:
    - ✓ The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated. No retaliatory actions will be used against me in the event of such complaint.
    - ✓ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - ✓ The right to receive confidential communications of protected health information.
    - ✓ The right to inspect and copy protected health information.
    - ✓ The right to amend protected health information.
    - ✓ The right to receive an accounting of disclosures of protected health information.
    - ✓ The right to obtain a paper copy of the Notice of Privacy Practices forms of this practice upon request.

This practice reserves all rights to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

SIGNATURE _____ **DATE** _____

Relationship to patient (if signed by personal representative of patient) _____