

Solomon Family Dentistry D.M.D., P.A.  
1971 N. Main Street  
Summerville, SC 29483

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES  
CONFIRMACIÓN DE RECIBO DE LA NOTIFICACIÓN SOBRE EL PROCEDIMIENTO DE  
PROTECCIÓN DE LA INFORMACIÓN PRIVADA**

I acknowledge that I have been provided the Notice of Privacy Practices.  
Confirmo haber recibido la Notificación sobre el Procedimiento de Protección de la información Privada.

Patient's Complete Legal Name:

Nombre legal complete del paciente

\_\_\_\_\_

(please print)

(Escriba con letra de imprenta, por favor)

Patient's DOB

Fecha de nacimiento  
del paciente

Date

Fecha:

\_\_\_\_\_

\_\_\_\_\_

Signature:

Firma:

\_\_\_\_\_

(Patient or legal guardian)

(Del paciente o del representante legal)

## **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)**

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

### **COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS**

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strove to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.