SHERMAN AND BRISCOE ORTHODONTICS

Darrel R. Sherman, D.D.S., M.S.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS
Patrick R. Briscoe, D.D.S., M.S.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

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 agree then you are bound to abide by such restrictions.

AUTHORIZATION FOR USE OF PRIVATE HEALTHCARE INFORMATION

HIPPA'S Privacy Rule requires covered entities (practices that send or receive insurance claims electronically) to obtain signed "authorization" to use or disclose information beyond treatment, payment or healthcare operations.
Your protected health information, including individually identifiable information, such as names, photographs, x-rays and study models, may be used or disclosed for the following purposes in this office:

(Please circle yes or no to optional use of name and/or diagnostic records)

YES **NO** Lectures and/or Professional Presentations (no use of names)

YES **NO** Display of names and photographs in this office (contests, contest winners, after-treatment portrait, etc.)

YES **NO** Display of names (first name only) and photographs on our internet sites including our website, Facebook and blog

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By signing below, I understand all topics listed above

Patient Name: _____

Responsible Name: _____ Relation to patient: _____

Signature: _____ Date: _____

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

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other