PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT

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I understand that,under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that I am not required to sign this form to obtain treatment, and that the following information can and will be used in order to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment directly and indirectly;
- Obtain payment from third-party payers;
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Clay Dental PLLC regarding its Notice Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of Clay Dental PLLC's Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Clay Dental PLLC restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. In general, there will be no other uses and disclosures of this information unless I permit it. However, I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone, or it is ordered by a court of law.

I understand that I may revoke this consent in writing at any time, except to the extent that Clay Dental PLLC has taken action relying on this consent.

I have received the Notice of Privacy Practice and have been provided an opportunity to review it.

DOB: _____

Patient / Representarive name: _____

Patient / Representarive signature: _____

Relationship to patient: _____

Date:_____