AUDC Dental Group, PLLC
DBA Amoskeag Family Dentistry
& Urgent Dental Care of NH

NOTICE OF PRIVACY ACKNOWLEDGEMENT(HIPAA)

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 this information can and will be used, but is not limited to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly including any other dentists or specialist to whom we are referring you to for treatment or evaluation.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your full length Notice of Privacy Practices or understand that I may request a copy of it at any time. The full length agreement contains a more complete description of the uses and disclosures of my health information. 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 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. I am being advised that I may receive phone, email or text messages about my appointments as well as messages left on answering machine or voicemail and I must request in writing if I do not wish to receive such communications. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

May We Discuss your medical/dental conditions with any member of your family or trusted individual? (please circle one) **YES** **NO**

If Yes, please name the individual(s) allowed:

_____

Patient Consent Signed by (print name) :_____

Relationship to patient: _____

Signature:_____ Date:_____