Akron
Periodontics & Dental
Implantology

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE PRIVACY PRACTICES

At **Akron Periodontics and Dental Implantology**, we are committed to protecting your personal health information in compliance with the **Health Insurance Portability and Accountability Act (HIPAA)**. This law gives you rights over your health information and sets rules and limits on who can view and receive it.

I acknowledge that I have received, reviewed, and understand **Akron Periodontics and Dental Implantology** *Notice of Privacy Practices*, which explains how my protected health information (PHI) may be used and disclosed by the practice. I understand that:

- My PHI may be used for **treatment, payment, and healthcare operations** as described in the *Notice of Privacy Practices*.
- I have the **right to request restrictions** on certain uses and disclosures of my PHI, though the practice is not required to agree to all requests.
- I may request **confidential communication methods** for receiving my health information.
- I have the **right to access, review, and obtain copies** of my PHI, as permitted by law.
- The practice may update the *Notice of Privacy Practices*, and I may request a copy at any time.

Authorization for Communication

I authorize **Akron Periodontics and Dental Implantology** to discuss my healthcare information with the following individuals:

1. **Name:** _____**Relationship:** _____ **Phone #**_____
2. **Name:** _____**Relationship:** _____ **Phone #**_____

☐ **I do not authorize my health information to be shared with anyone.**

Preferred Communication Method

Please indicate how you would like to receive appointment reminders and other non-sensitive healthcare information (check all that apply):

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email

I understand that text messages and emails may not be fully secure, and I accept the risks of receiving communication through these methods.

Acknowledgment & Signature

By signing below, I acknowledge that I have received and understand this *HIPAA Acknowledgment Form* and the *Notice of Privacy Practices*.

Printed Name: _____

_____

Signature of Patient or Legal Guardian **Date**

Office Use Only

If the patient or legal guardian did not sign this acknowledgment, please indicate the reason below:

☐ Patient declined to sign
☐ Communication barrier prevented acknowledgment
☐ Emergency situation prevented signing
☐ Other (explain): _____

Staff Member Signature: _____ **Date:** _____