NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting BEAUTIFUL SMILES DENTAL LLC AT 425-487-1551.

OUR NOTICE OF PRIVACY PRACTICES describes in more detail how your health information may be used and disclosed, and how you can access your information.

***CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.**

***OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.**

***CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

BY MY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ THE NOTICE OF PRIVACY PRACTICES. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.
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 HEALTHCARE OPERATIONS. 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.

_____ _____

Patient or legally authorized individual signature **Date**

_____ _____

Printed name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative, ect.)**

(NOTATION, IF ANY, BY STAFF)

THIS FORM WILL BE RETAINED IN YOUR MEDICAL/DENTAL RECORED.

LAST UPDATE _____/_____/_____