Notice of Privacy Acknowledgement

T. Kirk Crane
104 Exchange Place Ste. A
Lafayette, LA 70503

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 to:

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

I authorize Dr. Crane and/or members of his staff to release the following personal health information:

1. Dental services claims information
2. Prescriptions, diagnostic, treatment, and/or care management services

I authorized communication from the dental office by telephone, text, email, fax, postal service, or any means that the office feels efficient to contact me regarding the above mentioned statements that may contain PHI. **It is your responsibility to keep your personal passwords protected.**

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 you restrict how my private information is used or disclosed to carry out treatment, payment or health care 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 Name: ____________________
Relationship to patient: ____________
Signature:________________________ Date:____________

Office Use Only: Signature: ______________________ Date: ___________