Dr Rex A. Whiteman, DDS
218 Ave E
Apalachicola, Fl 32320
(850)653-9653

## 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 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.
*Obtain payment from third party payers.
*Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I received you Notice of Privacy Practices containing 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 at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Dr. Rex A. Whiteman, DDS restricts how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

I understand that Dr. Rex A. Whiteman, DDS will be happy to duplicate and make available at my request any x-rays that have been taken for the purpose of diagnosis. Dr. Rex A. Whiteman, DDS will retain all original x-rays and I agree to pay a duplication fee of $50 for these x-rays.

Patient name:_____

Relationship to patient:_____

Signature:_____Date_____

Office use only
I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below
Date_____ Initials_____ Reason_____