

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT  
(HIPAA ACT)  
PRIVACY POLICY ACKNOWLEDGEMENT  
WEST VALLEY PERIODONTICS

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
PATIENT'S DATE OF BIRTH: \_\_\_\_\_ SS: \_\_\_\_\_

I verify that the information given on health history form is true and correct.

- I understand that the office and staff of West Valley Periodontics will make every reasonable effort to protect my personal health information including my social security number, date of birth, address, and phone numbers.
- I understand that there may be times when the doctor and staff will need to speak with me regarding an appointment time, a test result or financial arrangements. If I am not at the number given, they have my permission to leave a brief message at my home or work number provided.
- I give my permission to West Valley Periodontics and staff to correspond with my general dentist, general physician, or specialist that I am under care with.
- I understand that my test result or health information will only be given to me or my legal guardian and cannot be given to my spouse or other family members.
- Upon my request, I will be given a full and complete copy of HIPAA privacy policy.
- If there are specific restrictions on use of my personal health information, I will notify West Valley Periodontics or Dr. Bohra in writing of these restrictions.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

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