

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
(HIPPA 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 Doctor 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.
- If I request, I will be given a full and complete copy of HIPPA privacy policy.
- If there are specific restrictions on use of my personal health information, I will notify west valley periodontics, Dr. Bohra , in writing of these restrictions.

Signature

Date

Legal Guardian if applicable