NOTICE OF PRIVACY POLICY – PATIENT ACKNOWLEDGEMENT

We at the dental office of Mark T. Albers, D.D.S. comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and are committed to safeguarding the privacy and confidentiality of your medical records, including the personal information you share with us. To assist us in protecting your privacy, please complete the following:

Patient Name (please print)_____

Date of Birth_____

May we leave a detailed voice mail message for you here:

Home Phone_____ Y N

Work Phone_____ Y N

Cell Phone _____ Y N

Email_____ Y N

What is your preferred contact number (or email) for appointment reminders – please circle:

Home Number Work Number Cell Phone Number Email

May we speak to someone else regarding your dental care? Y N

Name of Person(s)	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

I have been made aware of the privacy policies of Mark T. Albers, D.D.S. and have received (or reviewed and been given the option to receive) a copy of their Notice of Privacy Policies. I give my permission for Mark T. Albers, D.D.S., his assistants, hygienists, staff employees, and any other person treating or assisting in my treatment to discuss my dental needs with any person identified above, or with another health care provider. I also authorize the office to release any information acquired in the course of my examination or treatment for consultations or insurance purposes when needed.

_____ _____

Signature Date