YATES CENTER
DENTAL AND ORTHODONTICS
Dr. Matthew Standridge

HIPPA ACKNOWLEDGEMENT AND ASSESS LIST

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers. (Medical and Dental Insurance Companies)
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have the right, upon request, to review the Notice of Privacy that contains a more complete description of the uses and disclosures of my health information. I understand that Yates Center Dental and Orthodontics has the right to change its Notice of Privacy Practices from time to time and that I may contact Yates Center Dental and Orthodontics at any time to request a current copy of Notices of Privacy Practices.

I understand that I may request in writing that Yates Center Dental and Orthodontics restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Yates Center Dental and Orthodontics is not required to agree to my requested restrictions, but if Yates Center Dental and Orthodontics does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Yates Center Dental and Orthodontics has taken action relying on this consent.

I understand that any other parties that I list below can have access to my (patient) health information up to and including account balances.

I,_____, give consent to the following listed people access to my account:

_____
Name Relationship to patient

_____
Name Relationship to patient

_____
Name Relationship to patient

_____
Name Relationship to patient

_____
Name Relationship to patient

_____
Patient/Guardian Signature Date