ACKNOWLEDGEMENT OF PRIVACY PRACTICES
Chatham Oral & Maxillofacial Surgery, P.C.
310 Eisenhower Drive, Bldg. 1
Savannah, GA 31406
(912) 354-1515

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide / coordinate my treatment among different health care providers who may be involved directly or indirectly in that treatment.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my oral surgery provider's ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my oral surgery provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Patient Name:_____ Date: _____

Signature: _____

Relationship to Patient:_____

*Dependent family members also covered by this acknowledgement:

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other: _____