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**NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGEMENT**

Patient Name: _____ Date of Birth: _____

I have been given the opportunity to receive IMAGECARE'S Notice of Privacy Practices. I understand that this notice is Federally mandated and that it provides in detail the uses and disclosures of my protected health information that may be made by IMAGECARE, my individual rights and the IMAGECARE'S legal duties with respect to my protected health information. These include, but are not limited to the following:

- A statement that IMAGECARE is required by law to maintain the privacy of protected health information.
- A statement that they are required to follow the terms of the notice currently in effect.
- Types of uses and disclosures that can be made for each of the following purposes: Treatment, Payment, and Health Care Operations.
- A description of other situations where disclosure of protected health information is permitted or required without my consent or authorization.
- A description of uses and disclosures that are prohibited or limited by law.
- A description of disclosures that require my written authorization and how I may revoke authorizations.
- My individual rights with respect to protected health information and how I can exercise those rights in relationship to:
 - The right to complain to IMAGECARE and to the Secretary of HHS if my privacy rights have been violated and that no retaliatory actions will be taken because of such a complaint.
 - The right to request restrictions of certain uses and disclosures of my protected health. However, I understand that IMAGECARE does not have to agree to honor my requested restrictions.
 - The right to receive confidential communications of protected health information
 - The limited right to inspect and copy certain protected health information.
 - The right to request to amend protected health information.
 - The right to request an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from IMAGECARE upon request.

I also understand the IMAGECARE reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions for all protected health information that it maintains. Furthermore, if changes are made, I can obtain a revised Notice of Privacy Information upon request.

Signature: _____ Date: _____

Relationship to Patient {if signed by a personal representative of patient} _____
