HIPAA Acknowledgment of Receipt

Acknowledgment of Receipt of Notice of Privacy Practices

Avalon Dentistry

I acknowledge that I have received, or have been offered the opportunity to receive, a copy of Avalon Dentistry's **Notice of Privacy Practices**, which explains how my protected health information (PHI) may be used and disclosed, and describes my rights under federal HIPAA regulations and applicable Idaho law.

I understand that: - My health information may be used and disclosed for treatment, payment, and healthcare operations as described in the Notice. - Additional protections apply to certain sensitive health information as required by federal law. - Parents or legal guardians generally have the right to access the health records of unemancipated minor patients under Idaho law, with limited exceptions.

I understand that I may request a copy of the Notice of Privacy Practices at any time.

Patient Name (Print): _____

Patient / Parent / Legal Guardian Signature: _____

Relationship to Patient (if signing for a minor): _____

Date: _____

If the patient or legal representative refuses to sign this acknowledgment, the practice may document the refusal and the reason, if known, in accordance with HIPAA requirements.