DRS SCANNELL AND HOLLINGER INC

79 Maple Street, East Longmeadow MA 01028

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

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 and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

□ Obtain payment from third-party payers for my health care services (insurance companies)

□ Conduct normal health care operations such as quality assessment and improvement activities I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information.

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:

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AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or dental treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

□ You May Disclose My Information To The Following □ Do Not Disclose My Information to Anyone But Me

1. __________________________________ Relationship to Patient: ______________________ Date: ________
2. __________________________________ Relationship to Patient: ______________________ Date: ________

Office Use Only- We were unable to obtain written acknowledgement of our notice due to:
□ Refusal to sign □ Communication Barrier □ Emergency Situation □ Other