Kissimmee Childrens Dentistry
595 Oak Commons Boulevard Suite C
Kissimmee, FL 34741
(407) 870-0717

Acknowledgement Notice Of HIPPA Privacy Act

I _____ as parent/legal guardian of

(Patient's Name) _____ am acknowledging that the staff of Kissimmee Childrens Dentistry has notified me that they honor the Government HIPPA Privacy Act.

By signing this document, I am giving permission to file my dental insurance, to refer me to any necessary specialists and for Kissimmee Childrens Dentistry and/or staff to discuss any information in my dental records necessary for the overall well-being of my dental health.

I understand that Kissimmee Childrens Dentistry and/or staff will not sell or share my personal information with any other organization or third party.

I also understand that I have the right to refuse to sign this notice; however, my refusal would require payment in full for all dental treatment and waive the courtesy of having dental insurance filed on my behalf. My refusal would also deny Kissimmee Childrens Dentistry the ability to discuss my dental health with a specialist or any staff members. I understand that this would cause the inability for treatment to be performed due to lack of personnel.

X _____
Signature of Parent/Legal Guardian

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but could not do so for the following reason:

_____ Individual/Parent/Legal Guardian refused to sign

_____ Communication barriers prohibited acknowledgement

_____ Other – please specify _____