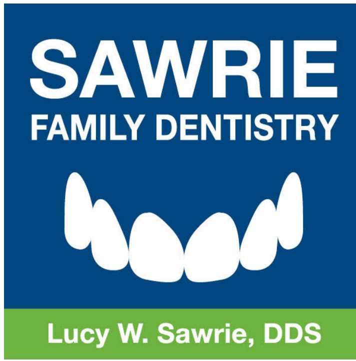

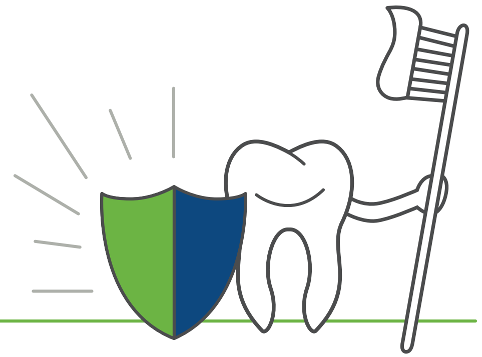

ACKNOWLEDGEMENT AND AGREEMENT WITH PRIVACY POLICIES

I understand the patient's protected health information ("PHI") is private and confidential. I understand SAWRIE FAMILY DENTISTRY(SFD) works very hard to protect a patient's privacy and preserve the confidentiality of a patient's personal health information.

I understand SFD may use and disclose the patient's PHI to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of PHI without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.

SAWRIE FAMILY DENTISTRY possesses a detailed document called "Notice of Privacy Practices." It contains more information about the policies and practices protecting a patient's PHI, and is included as part of this Acknowledgment. I understand that I have the right to read the "Notice of Privacy Practices" before signing this Acknowledgment.

SFD may update this Acknowledgment and "Notice of Privacy Practices." If I ask, SFD will provide me with the most current "Notice of Privacy Practices." Within this "Notice of Privacy Practices" is a complete description of my privacy/ confidentiality rights. These rights include, but aren't limited to: access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law and requesting communication occur by specified methods of communication or alterative action.

SAWRIE FAMILY DENTISTRY established procedures help it meet its obligations to patients. These procedures may include other signature requirements, written acknowledgments, and authorizations; reasonable time frames for requesting information; charges for copies and non—routine information needs; etc. I will assist SFD by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices."

I read and fully understand the above acknowledgment, consent, and agreement with privacy practices.

______________________________	______________________________	__________
PATIENT SIGNATURE (OR PARENT/GUARDIAN IF MINOR)	PRINTED NAME	DATE

1229 Taft Highway, Signal Mountain, TN 37377

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