

Heathcote Dental

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Notice of Privacy Practices Patient Acknowledgement

Patient Name

Date

I understand that, under the Health Insurance Portability and Accountability Act of 1996, I have certain rights in regards to my protected health information. I have received read and understand the Statement of Privacy Practices.

The practice reserves the right to change the terms of its Statement of Privacy Practices. I understand the practice will provide a current Statement of Privacy Practices upon request.

Patient Signature (parent if a minor)

Date

Relationship to patient, if not self