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**Notice of Privacy Practices**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the health portability and accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved on that treatment directly and indirectly.
- Obtain payment from third party payers for my health care services.
- Conducts normal Healthcare operations such as 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 have been given the right to review and receive a copy of notice of privacy practices at my request. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I make contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request and writing that you restrict how my private information is used or disclosed to carry out treatment, payment or Healthcare operations and I understand that you are not required to agree to my requested restrictions but if you do agree that you are bound to abide by such restrictions.

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**I authorize my provider to disclose my private information to the person or persons listed below:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement: \_\_\_\_\_

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**For Office Use Only**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The Patient refused to sign     Communication barriers     Other