Modern Dental Associates
Joshua A. Parry DMD, and Associates
1040 Town Square
Greensburg, PA 15601
724-836-3368

HIPAA Acknowledgement of Receipt of Notice of Privacy Practices

With my consent, Modern Dental Associates may use and disclose protected health information about me to carry out treatment, payment, and insurance authorizations and payment requests. Please refer to our Clinical Notice of Privacy Practices for a complete description of such uses and disclosures. Our practice provides this form to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996.

Date : _____

I acknowledge that I was provided with a copy of Modern Dental Associates' Notice of Privacy Practice.

Patient Name (Print) _____

Patient Signature _____

If completed by a patient's personal representative (or if the patient is a minor), please print and sign your name in the space below.

Personal Representative/Guardian (Print) _____

Personal Representative/Guardian (Signature) _____

Relationship to Patient _____

If permission is granted to share your health and dental information with a family member(s), please list the name of the person below and your relationship :

_____

Name Relationship