

Acknowledgement of Privacy Practices

Dr. Ryan H. Yim - Dr. Edmund A. Cassella - Dr. Allison P. Tran
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(808) 955-1506

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinated my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of Dr. Ryan H. Yim or Dr. Edmund A. Cassella, Dr. Allison P. Tran, *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the opportunity to review the Notice of Privacy Practices and the option to receive a copy of the Notice upon request. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

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

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement: _____

I give Dr. Ryan Yim or Edmund Cassella or Dr. Allison Tran or a member of their staff permission to discuss my treatment and/or treatment plan/financial with: *(Please Initial)*

Any member of my immediate family _____ Yes _____ No

Spouse Only _____ Yes _____ No

Other-Specify (i.e. girlfriend/boyfriend, grandparent)..... _____ Yes _____ No

For Office Use Only:

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

- Patient refused to sign
- Communication barriers
- Emergency situation
- Other: _____