# NOTICE OF PRIVACY PRACTICES
## ----- HIPAA -----

The Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy and Practices is a federal program that requires all Dental/Medical records and other individually identifiable health/dental information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. One of the main goals of HIPAA is the prevention of healthcare fraud.

I have read and acknowledge the HIPAA notice for my child/children:

CHILD NAME: FIRST & LAST | CHILD NAME: FIRST & LAST | CHILD NAME: FIRST & LAST

I give consent and authorization of the HIPAA notice to the office of Dr. Brett M. Quackenbush and staff. I also acknowledge that I have read and understand the Financial Policy of this office:

PARENT / GUARDIAN SIGNATURE | DATE