HYATT FAMILY DENTAL

8711 BEDFORD-EULESS ROAD
HURST, TEXAS 76053
817 589-0496

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your ***Notice of Privacy Practices*** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time 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. I also understand 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_______________________________ Relationship to Patient___________________________________
Signature:____Date_____________________________________
The following person/s are allowed access to my Dental Information, Records, and Radiographs (X-rays).

____
Name and Relationship

Images/Testimonial Release Form

Testimonial Statement and Images/Videos Materials:
X-RAYS, PHOTOS, VIDEO, TESTIMONIAL OF SERVICES

Authorization and Release Information

I understand my testimonial or images/videos as outlined above (the "Testimonial") and made on behalf of CLINTON HYATT, DDS (hereinafter called "The Practice") may be used in connection with publicizing and promoting The Practice. I authorize The Practice to use my name, and the Images/Videos/Testimonial as defined on this form.

I hereby irrevocably authorize The Practice to copy, exhibit, publish or distribute the Image(s), Video(s), and/or Testimonial for purposes of publicizing The Practice or for any other lawful purpose. These images/videos/statements may be used in printed publications, multimedia presentations, on websites or in any other distribution media. I agree that I will make no monetary or other claim against The Practice for their use.

In addition, I waive any right to inspect or approve the finished product, including written copy, wherein my likeness or my testimonial appears.

I hereby hold harmless and release The Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I have read the authorization and release information and give my consent for the use as indicated above.

PATIENT PRINTED NAME:
____
PARENT/GUARDIAN PRINTED NAME:
____
PATIENT/GUARDIAN SIGNATURE:
____
WITNESS PRINTED NAME/SIGNATURE:
____