SMITHFIELD FAMILY DENTISTRY
NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGEMENT

Our *Notice of Privacy Practices* provides information about how we may use and disclose medical and dental information about you. As provided in our notice, the terms of our notice may change. If we change our *NOTICE,* you may obtain a revised copy.

I, _____, have read the **Smithfield Family Dentistry** *Notice of Privacy Practices*.

I understand that I may ask questions to **Smithfield Family Dentistry** staff if I do not understand any information contained in the *Notice of Privacy Practices.*

Smithfield Family Dentistry has the right to disclose relevant health and dental information to my family member, other relative, close personal friend, or anyone identified by me including:

Name:	**Relationship to patient:**
_____	_____
_____	_____
_____	_____
_____	_____

Patient's Signature_____Date_____

Authorized Patient Representative_____Date_____

Relationship to Patient_____

DEEMED CONSENT

I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a **Smithfield Family Dentistry** healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

Patient's (or Guardian's) Signature_____Date_____

Witness_____Date_____