



## HIPAA AWARENESS FORM

I hereby acknowledge that I am aware that the office of Dr. Mark Freeman D.D.S. and Associates abide by the policies set forth by the Federal Government's HIPAA regulations, and understand that a comprehensive outline of their HIPAA office policies is available to me upon my request.

PATIENT: \_\_\_\_\_

*(Signature of patient / signature of parent)*

DATE: \_\_\_\_\_