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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the HEALTH INSURANCE PROTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPPAA), 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 dental treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have read and understand your Notice of Privacy practices containing a description of the uses and disclosures of my health information. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may obtain a copy of the Notice of Privacy Practices is I wish to do so.

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 that you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

PRINT NAME _____

SIGNATURE _____

DATE _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this notice of Privacy Practices, but was unable to do so as documented below.

Date_____Initials_____

Reason_____