

FAMILY DENTAL OF NORMAN

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance portability and accountability Act of 1996 ("HIPPA"), 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 you 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 Notices of Privacy Practices from time to time and that I may contact this organization at any time at the 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 of healthcare 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 restorations.

Print Name of patient: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

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

Date: _____

Initials: _____

Reason: _____