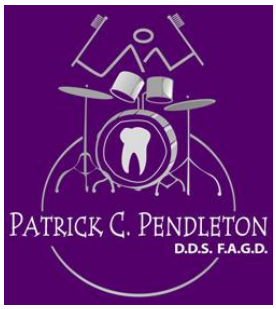

ACKNOWLEDGMENT
OF
PRIVACY PRACTICES

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

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office 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 and I understand that 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:_____Date_____

Signature:_____
Relationship to Patient:_____
Dependent family members also covered by this acknowledgment:

***Signing this acknowledgment also gives consent to our office in displaying a photo of your child/children on our "NO CAVITY CLUB" board if applicable.**
<u>For Office Use Only</u>:
We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reasons:

- **The patient refused to sign.**
- **Communication barriers.**
- **Emergency situation.**
- **Other**