

# NOTICE OF PRIVACY ACKNOWLEDGEMENT

## East End Tooth Ferry Pediatric Dentistry PLLC

I understand that under the Health Insurance Portability & 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 operation such as quality assessments and physician certifications.

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its Notice Of Privacy Practices from time to time and that I may Contact this organization at any time at the address above to obtain a current copy of the Notice Of Private 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. 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 restrictions.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Staff Member Sign: \_\_\_\_\_

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### 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: \_\_\_\_\_