



ROCK ISI AND

15 > DENTAL ASSOCIATES 2021

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan, and direct my treatment and follow-up amount 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 your *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 *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the office address 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. 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: self / guardian / POA

Signature: _____ Date: _____

The following person(s) may receive disclosure of protected health information about me:

1. _____ relationship: _____
2. _____ relationship: _____
3. _____ relationship: _____