NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PASSES DENTAL CARE
415 NORTHERN BLVD.
GREAT NECK, NY, 11021

I understand that under Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 physicians certifications

I have received, read and understand the **Notice of Privacy Practices** containing a more complete description of the uses and disclosure of my health information. I understand that the organization has the right to change is **Notice of Privacy Practices** from time to time and that I may contact the organization (The U.S. Department of Health & Human Services) at its toll free number 1-877-696-6775 at any time to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how private my 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: _____

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OFFICE USE ONLY

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

Date:_____ Initials:_____ Reason:_____