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 payments from third party payers.
- Conduct normal healthcare operations such as quality assessments and Physician certifications.

I acknowledge that I can receive the *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 address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Marquis Sleep and Family Dentistry restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Marquis Sleep and Family Dentistry is not required to agree to my requested restrictions but if Marquis Sleep and Family Dentistry does agree then Marquis Sleep and Family Dentistry is bound to abide by such restrictions.

Patient Signature _____

Relationship to Patient _____

Date _____

OFFICE USE ONLY

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

Date / Signature / Reason: _____

_____