

Mary K. Mitchell, D.D.S.

NOTICE OF PRIVACY ACKNOWLEDGEMENT

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 operations such as quality assessments and physical 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 Mary K. Mitchell, D.D.S. has the right to change its Notice of Privacy Practices from time to time and that I may contact them at any time to obtain a current copy of these 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 healthy 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.

PLEASE PRINT

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

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below: