

**ACKNOWLEDGEMENT OF RECEIPT OF  
HIPAA NOTICE OF PRIVACY PRACTICES**

*Nicholas R. Smith, D.D.S., M.S., P.C.*

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 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 physician certifications.

I have received 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 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.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

*Please Note: It is your right to refuse to sign this Acknowledgement.*

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Signed (Patient or Legal Representative for Patient)

\_\_\_\_\_  
Date

Authority of Legal Representative to Sign for Patient (check one):

Parent       Guardian       Power of Attorney       Other: \_\_\_\_\_

\_\_\_\_\_  
*Office Use Only*

An attempt was made to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

\_\_\_\_ A communication barrier prevented us from obtaining acknowledgement.

\_\_\_\_ The individual was unwilling to sign.

\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_\_  
Staff Member Signature

\_\_\_\_\_  
Date