NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Pediatric Dental Specialists, PLLC
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Greenville, MS 38703
(662)-334-9337

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 physician certifications.

I acknowledge that I have received 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 address above 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 that 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's Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Official Use Only

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

Date: Reason: Initials: