



NEW LENOX DENTAL GROUP

1600 W Lincoln Highway

New Lenox, IL 60451

(815) 485-2345

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this 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:

1. Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician 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 this organization has the right to change its *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 operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient _____

Signature _____ Date _____

FOR OFFICE USE ONLY

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

Date: _____ Reason: _____ Initials: _____