KIDDSMILES
PEDIATRIC DENTISTRY

NOTICE OF PRIVACY ACKNOWLEDGMENT KIDDSMILES, PLLC

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 operation such as quality assessments and physician certifications.

I have received, read and understand your Notice Of Privacy Practices from time to time and that I may Contact the organization at any time at the address above 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.

_____

Patient

_____

Relationship to Patient

_____

Signature

_____

Date

Staff Member Sign: _____

OFFICE USE ONLY

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

Date:_____ Initials:_____ Reason:_____