ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICE:

I understand that under *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, I have certain rights to privacy regarding my protected Health Information describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand this information can and will be used to:

1) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2) A means by which a third-party payer can verify that services billed were actually provided.
3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action I reliance thereon. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

By signing below, I acknowledge that I have been provided a copy of a more complete description of information and disclosures from ***Esthetic & Implant Dentistry of South Florida 24/7 Urgent Dental Care.*** *Notice of Privacy Practices* and have therefore been advised of how health information about me may be used and disclosed by the Corporation and how I may obtain access to and control this information. I also acknowledge that the Corporation may use and disclose my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the Corportation, its staff and its facilities.

Patient Name:_____ Witness Name:_____

Patient Signature:_____ Witness Signature:_____

Date of Acknowledgement:_____