

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

**James A. Maxwell Jr. DDS
2210 Olympic Street
Springfield, Ohio 45503**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. This office has a *Notice of Privacy Practices* that describes how they may use and disclose protected health information about me. 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 understand that I have the right to review your *Notice of Privacy Practices*, which contains 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.

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 name _____

Relationship to patient _____

Signature _____

Date _____

OFFICE 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:

Reason: _____