NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
MAZZELLA FAMILY AND COSMETIC DENTISRY

I understand that under the Health Insurance Portability Act of 1996 ("HIPAA"), 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 or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Mazzella Family and Cosmetic Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Mazzella Family and Cosmetic Dentistry at any time 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 and 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: _____

Relationship to Patient: _____

Signature: _____ Date: _____

IF ANYONE <u>SHOULD NOT</u> HAVE ACCESS TO THE PATIENT'S MEDICAL OR FINANCIAL INFORMATION, PLEASE STATE THEIR NAME(S) HERE:

Name: _____ Date: _____

Name: _____ Date: _____

OFFICE USE ONLY

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

Date	Initials	Reason