Regency Dental
Dr. Donna T. Burton, DDS

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Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act (HIPPA) of 1996, 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 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* 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 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 requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Please Print) _____

Patient Signature _____

Relationship to Patient _____

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: