## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability & Accountability 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 by **Blue Hill Family & Cosmetic Dentistry** 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; and
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request to read a copy of the **Notice of Privacy Practices** which contains a more complete description of the uses and disclosures of my health information.

I understand that **Blue Hill Family & Cosmetic Dentistry** has the right to change its Notice of Privacy Practices from time to time and that I may contact the office 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, or health care operations. I also understand that **Blue Hill Family & Cosmetic Dentistry** is not required to agree to my requested restrictions, but if it does agree, then it is bound to abide by such restrictions.

I have read and understand the above Acknowledgment and agree to its terms.

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Patient Signature (parent or guardian if a minor) Date