OVERLAND DENTAL
2720 Overland Road
Boise, ID 83705

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly;
2. Obtain payment from a third-party payer; and
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand our ***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 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 healthcare 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 acknowledgment of the ***Notice of Privacy Practices***, but was unable to do so as documented below:

Date: Initials: Reason: