# Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for treatment, payment, and other healthcare operations. I have received, read, and understand **Zirker Family Dentistry's** Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information.

I understand that **Zirker Family Dentistry**, has the right to change its Notice of Privacy Practices from time to time and that I may view the most current Notice at **zirkerfamilydentistry.com** or by requesting a current copy from the office.

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 Zirker Family Dentistry, is not required to agree to my requested restrictions if Zirker Family Dentistry, is otherwise permitted to use or disclose the information under HIPAA. I agree that only a written agreement to my requested restrictions will be effectual and binding upon the Practice.

Patient Name: _____ _____
(Relationship to patient if Minor)

Signature: _____ _____
(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however, acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining acknowledgement
- An emergency prevented us from obtaining acknowledgement
- Other: _____