

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

*Springfield Smiles*

Christian A. Victor, D.D.S., Inc.  
413 E. Home Rd.  
937-390-3077

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 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 had the opportunity to read and understand Springfield Smiles Notice of Privacy Practices, Dated November 2, 2009, containing a more complete description of the uses and disclosures of my health information. I understand that the office has the right to change its Notice of Privacy Practices from time to time and that I may contact the office staff at any time at the address above to obtain a copy of the Notice of Privacy Practices.

**If you wish for someone else to have access to your private medical information (such as your parents if you are 18 or over), please list their name(s) below:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\*\*\*\*\*

Patient Name: (Filled in electronically)

Signature of Patient or Guardian: (To be signed electronically) Date: (Filled in electronically)

**If you have Guardianship or Power of Attorney for this patient, please provide appropriate documentation.**

OFFICE USE ONLY

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

Date: \_\_\_\_\_ Initials: \_\_\_\_\_ Reason: \_\_\_\_\_