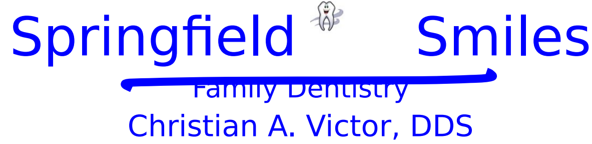

Christian A. Victor, DDS

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 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 February 10, 2016, 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: ___________________________

Signature of Patient or Guardian: ________________________________ Date: _______________________

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: ____

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