(Acknowledgment Of)

NOTICE OF PRIVACY PRACTICES

Rusty M. Albrecht D.D.S., Inc.
9659 Old Johnnycake Ridge Road
Concord, Ohio 44060
(440)358-0495

I understand that, under the Health Insurance Portability And 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 health-care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations, such as quality assessments and physician Certification.

I acknowledge that a copy of **Notice Of Privacy Practices** is available to me upon request 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 anytime at the address above to obtain a current copy of such **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 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: _____________

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement of the above affidavit, but was unable to do so as documented below:

Date__________________ Initials________ Reason______________________________