NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Candace M. Opon D.D.S. Ltd.
College Hill Professional Building
690 N Route 31, Suite G
Crystal Lake, IL 60012

I understand that, under the Health Insurance Portability & 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 to:

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

I have received, read, and understand your *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 the organization at any time at the address above to obtain a current copy of *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_____

OFFICE USE ONLY

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

Date:_____Initials_____Reason_____