RENÉ F. CEDEÑO
D.M.D.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

CLICK TO SUBMIT

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 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 acknowledge that I have received 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 this organization at any time at the address above to obtain a current copy of the *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 Signature_____

Relationship to patient _____

Parent/Guardian Signature _____

Date _____

Office Use Only

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

☐Individual refused to sign

☐Communication barrier prohibited obtaining the acknowledgement

☐An emergency situation prevented us from obtaining acknowledgment

☐Other _____