

**Dr. Salman's Dental**

927 Armory Rd.

Barstow California, 92311

Notice of Privacy Practices Acknowledgement

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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understood 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 it's *NOTICE OF 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*.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature \_\_\_\_\_

Date: \_\_\_\_\_

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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, or patient did not sign on own will.

Initials \_\_\_\_\_ Date \_\_\_\_\_