

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

**Deer Creek Dental  
12321 Hidden Forest Blvd  
OKC, OK 73142**

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 treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessment 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.

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 that 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 (mother, father, etc...) \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

---

**OFFICE USE ONLY**

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

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

Reason \_\_\_\_\_