NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & 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 payers.
- 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 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 healthcare 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.

ELECTRONIC COMMUNICATION CONSENT

I acknowledge that the practice may send the following to my **email** or **cellular device** (Please circle). Please initial next to each that apply.

______ Information about my treatment plan
______ Information about my dental visit
_____ Information about my accounts payable
_____ Information about my dental records

ACKNOWLEDGEMENT

______ I am responsible for providing the dental practice of any updates to my email address or cellular device
______ I am able to receive information electronically and store is securely away from public computers
______ I can withdraw my consent to electronic communications by contacting the office.
______I hereby authorize that Sam Koo, D.D.S., P.A. may disclose my personal information to the following person(s)

Name	Telephone Number	Relationship to Patient

Patient Name ____ Date _____________________

Patient/Guardian Signature____

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 ____