CAPITAL CITY

PERIODONTICS & ORAL IMPLANTOLOGY

# 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. This document acknowledges that I have been offered and / received a more complete copy of the Notice of Privacy Practices. 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 below to obtain a current copy of the Notice of Privacy Practices.

By completing the following information, I am giving Capital City Periodontics the authority to speak with individuals indicated below regarding my healthcare treatment and financial information relative to treatment being performed by Capital City Periodontics.

_____ Right to correspond with family members as listed:

_______________________________________________________________________

_______________________________________________________________________

_____ Right to correspond with all doctors involved with my healthcare

I, ______________________________________________ (Patient) acknowledge that I have received a copy of the Notice of Privacy Practices.

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Patient, Parent or Legal Guardian Signature Date

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Relationship to patient

___

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 |
|---|---|---|
| | | |