NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

EOLA DENTAL
405 N. EOLA RD. SUITE L
AURORA, IL 60502
630-236-6300

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 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 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.

Patient Name: _____

Your Relationship to the Patient:_____

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