Center for Smile Enhancement . Michael S. Sudit, D.D.S. LLC
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(952) 593-9310

Health Insurance Portability and Accountability Act Form

I understand that, under the Health Insurance Portability and Accountability Act (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 followup among 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 certifications

I acknowledge that I have reviewed the *Notice of Privacy Practices* which contains a complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the *Notice of Privacy Practices* and that I can obtain a current copy at any time.

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 than you are bound to abide by such restrictions.

Print Patient Name: _____

Relationship to Patient: _____

Patient/Guardian Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of our Notice of Privacy Practices on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date_____ Name _____ Reason_____