# 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 Private 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 health care 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 _____

Relationship to Patient: _____

Signature _____

Date _____

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OFFICE USE ONLY

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

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Date: Initials Reason:

*Kristal A. Izydorczyk, DMD*
GENERAL & COSMETIC DENTISTRY
1632 BROADWAY AVENUE
PITTSBURGH, PA 15216
TELEPHONE (412) 531-2329
FAX (412) 531-8511

# HIPAA CONSENT
## CONSENT TO LEAVE MESSAGE

Patient Name:_____ Date:_____
(print)

I wish to be called at home ☐ ; other ☐ (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

_____home _____other

I do ☐, I do not ☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do ☐, I do not ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:

_____

_____

_____ _____
Patient Signature Date