NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

LEGACY FAMILY DENTAL, P.C.
DR. JAMIE A. GRIDER

I understand that, under the Health Portability & Accountability Act of 1996 ("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 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 understand your *Notice of Privacy Practices* regarding 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 to obtain a current copy of the *Notice of Privacy Practices.*

I authorize Dr. Jamie Grider to release to staff, physicians, hospitals, health care service plans, insurance companies, self-insurers, or their representatives, any and all information, records and x-rays regarding my medical history, services rendered and treatment necessary and obtain any information necessary for treatment.

Patient Name: ____

Relationship to Patient: ____

Signature: ____

Date: ____

OFFICE USE ONLY

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

Date:__________ Initials:__________ Reason:___________________________________