NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

AZ Dental Health Inc.
Jeffrey B. Pico D.D.S.
2500 S. Power Rd. #105
Mesa, AZ. 85209

I understand that under the Health Insurance 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 payors
Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your **Notice of Privacy** 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** from time to time and that I may contact this organization any time at the address above to obtain a current copy of the **Notice of Privacy.**

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:_________________________

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**