H.I.P.P.A. Acknowledgement

I understand that under the Health Insurance Portability Act of 1996(HHIPA), I have certain rights to privacy regarding my protected health information, I understand that this information will be used to:

-Conduct, plan and direct my treatment and follow-up among the multiple health care peoviders who may be involved in that treatment directly and indirectly.

-Obtain payment from third party payers

-Conduct normal health care operations such as quality assessments and physician certifications

I acknowledge that I have received the Notice of Privacy Practices of Glenmont Dental containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's 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 health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree you are bound to abide by such restrictions.

Signature: ______________________________

Print Name: ______________________________

Date: ______________