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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physicians 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 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 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: _____

OFFICIAL 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 _____