

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY RULES

Tooth Fixer Dental

2460 S. Eola Road
Aurora, IL, 60504
(630) 585-5600

My signature confirms that **I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)**. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete describing of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I, _____, have received a copy of the *Notice of Privacy Practices* of the office of Dr. Khaja Mohsinuddin. If signing on behalf of patient please inform the office of your relationship to the patient: _____

Please initial:

_____ Yes it is okay to **call or leave a message at work**.

_____ Yes it is okay to **leave a message on my answering machine/voicemail at home**.

_____ Yes it is okay to **leave a message with a family members**.