westrock
ORTHODONTICS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), 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 health care providers who may be involved in that treatment directly or 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 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 to obtain a copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Westrock Orthodontics may restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Westrock Orthodontics is not required to agree to my requested restrictions, but if Westrock Orthodontics does agree, then Westrock Orthodontics is bound to abide by such restrictions.

Patient Name ____

Relationship to Patient ____

Signature ______________________________ Date ______________________

List below any person who can receive HIPAA information on this patient.

Name ____________________ Relationship ______________ ☐ Treatment info ☐ Ledger

Name ____________________ Relationship ______________ ☐ Treatment info ☐ Ledger

Name ____________________ Relationship ______________ ☐ Treatment info ☐ Ledger

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: