NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

WHITE SPRUCE DENTAL, PLLC
935 EAST HENRIETTA ROAD
ROCHESTER, NY 14623

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 healthcare providers who may be involved in that treatment directly and indirectly.

★ Obtain payment from third-party payers.

★ Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures or my health information. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from the 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 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 allow you to give my clinical information to or answer questions from:

_____ _____

Please print name(s) other than self above

_____ _____

Patient Signature *Today's Date*

_____ _____

Print Patient Name *Patient's Birth Date*