



## PATIENT ACKNOWLEDGEMENT OF HIPAA PRACTICES

Patient Name

Date of Birth

I have received Dr Mark R. Bydalek's Notice of Privacy Practices plainly written. The notice provides in detail the uses and disclosures of my protected health information that may be made in this dental office. My individual rights and the Practice's legal duties with respect to my protected health information include

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms and the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes, i.e., treatment, payment and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
- My individual rights with respect to protect health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to Dr Bydalek's practice and to the Secretary of HHS if I believe my privacy rights have been violated and that no retaliatory actions will be used against me in the event of such a complaint
  - The right to request restrictions on certain uses and disclosures of my protected health information and this practice is not required to agree to a requested restriction
  - The right to receive confidential communications of protected health information
  - The right to inspect and copy protected health information
  - The right to obtain an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practice from this practice upon request

The Practice reserves the right to change the terms of this Notices of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

Signature

Date

Relationship to patient – if signed by a personal representative of patient