

# Notice of Privacy Practices Acknowledgement

**Brian S. Dolberg, D.D.S.  
4390 N. Miller Rd. Suite 106  
Scottsdale, AZ 85251**

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 the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among any healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers for you.
- Conduct normal healthcare operations such as quality assessments.

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 office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing to you 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:

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Relationship to Patient:

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Signature:

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Date:

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## 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\_\_\_\_\_

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