NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

KENDRA J. ZAPPIA, D.D.S., LLC

PINE WEST PLAZA, BLDG. #3

WASHINGTON AVENUE EXTENSION

ALBANY, NEW YORK 12205

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 certifications.

I acknowledge that, upon request, I will receive 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 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 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_____

Relationship to Patient_____

Signature_____

Date_____

Do we have your permission to leave a message on an answering machine? Yes No