KEVIN SORGE, DDS
EXCELLENCE IN DENTISTRY

# Notice of Privacy Practices Acknowledgement

I understand that, under 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 I have received the *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 copy of the *Notice of Privacy Practices.*

_____ I authorize that I give my permission to Dr. Sorge and his representatives to speak with
Initials
_____ regarding treatment, medical and account information.

I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment and 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: ◯ Self ◯ Other: _____
(Please specify what relationship to patient is.)

Signature:_____ Date:_____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement to the *Notice of Privacy Practices Acknowledgement,* but was unable to do so as documented below:

_____
Initials Date Reason

_____