NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
HEALTHY SMILES OF NORTHWEST INDIANA
Nicholas Cain, D.D.S.
4629 Melton Road
Gary, IN 46403

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PRINTED NAME OF PATIENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), 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 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 understand that this organization has the right to change It's 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.

I also hereby authorize the dental practice named above to discuss my dental treatment information and,
Dental financial information (which includes all information classified as Protected Health Information or PHI under the federal law HIPPA) at said dental practice with the following persons who shall be active in my dental care. I understand that to revoke this authorization, I must notify the dental practice above in writing.

_____ _____
Name of authorized recipient Relationship

_____ _____
Name of authorized recipient Relationship

_____ _____
Patient or Parent/guardian signature Date