Notice of Privacy Practices Acknowledgment

SNYDER FAMILY DENTISTRY
2700 84TH STREET SW
PO BOX 367
BYRON CENTER, MI 49315

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 the multiple healthcare providers who may be involved in the 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, or have the right to request Snyder Family Dentistry's Notice of Practice Policies 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 Snyder Family Dentistry 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 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: _____

Name of person(s) we may share information with: _____

_____

Patient Signature: _____Date:_____

Snyder Family Dentistry may leave a message: **On my cell phone: _____**

On my home phone: _____