

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

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 Johnson & Montoya Dental, P. C. uses protected health information for:

- ❖ Conducting, planning and directing treatment among multiple healthcare providers who may be involved in that treatment directly and/or indirectly
- ❖ Obtaining payment for treatment
- ❖ Conducting normal healthcare operations

Any other uses or disclosures will be made only with written consent.

I have been informed and given the right to review and/or obtain a personal copy of Johnson & Montoya Dental, P.C.'s complete *Notice of Privacy Practices* prior to signing this acknowledgement.

Signature \_\_\_\_\_ Date \_\_\_\_\_