CAPITAL ENDODONTICS

Notice of Privacy Acknowledgement

2418 Crossroads Dr., Ste. 2900 Madison, WI 53718 • 8333 Greenway Blvd., Ste. 380 Middleton, WI 53562

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 have received, read and understand the Notice of Privacy Practices which contains 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 anytime 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 healthcare 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: _____

Patient Signature: _____

Date: _____

Relationship to Patient: _____
(if you are accompanying a minor or have power of attorney)

If you'd like your spouse or other family member to have access to your files, please fill in below:

I, _____ authorize _____
to have access to my medical and/or financial records at Capital Endodontics.

Patient Signature _____ Date _____