



PATRICIA A. LOTT

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
For the dental practice of
PATRICIA A. LOTT, DDS PC

Under the Health Information Portability & Accountability Act of 1996 (HIPAA), I understand that I have certain rights to privacy regarding my protected health information. I understand and acknowledge that this information can and will be used to:

- Deliver, plan and direct my treatment and follow-up among the various Healthcare providers who may be directly or indirectly involved
- Obtain payment from third party payers
- Perform normal healthcare operations

I have had an opportunity to read, ask questions and understand the HIPAA Practices Manual containing a more detailed and complete description of the uses and disclosures of my health information. I understand that the practices of Patricia A. Lott, DDS, PC has the right to change its *Notice of Privacy Practices* from time to time. I may contact this office at any time to view a current copy.

I understand that I have the right to request in writing to restrict how my private information be used or disclosed to carry out treatment or payment of dental services. I also understand that this office is not required to agree to my requested restrictions. If this office should agree, then it is bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

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

Date _____	Initials _____
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