**Notice of Privacy Practices Acknowledgement**

Rodney D. Hyduk, DDS, MSD, PC
90 W. Square Lake Rd.
Troy, MI 48098

42450 Garfield
Clinton Twp. MI 48038

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.
- Bill third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that a copy of your Notice of Privacy is available for review upon request, containing a more complete description of the uses and disclosures of my health information.

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:_____

Signature of Patient (Parent if Minor):_____

Relationship to Patient (if parent):_____

Date:_____

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Office use only

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

Date Initials Reason

_____
_____
_____