Notice of Privacy Practices Acknowledgement
Consent for Use and Disclosure of Health Information

Miskovich Dental Clinic, P.C.
1121 SE 4th Ave
Grand Rapids, MN 55744

I understand that, under 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 your Notice of Privacy Practices 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 this organization at anytime at the address above to obtain a current copy of the Notice of Privacy 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 _____

Relationship to Patient _____

Signature _____

Date _____

Authorization
I authorize Miskovich Dental Clinic, P.C. caregivers and personnel to disclose information regarding my health condition and care to the following individuals:

Name	Relationship to Patient

You are entitled to a copy of this consent after you sign it, upon request.

For Office Use
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.
Date: Time: Reason: