Peter J Adams DDS
502 Bud Drive Suite 102
Chesapeake, VA 23322
(757)547-0222

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 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 any time 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 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*: _____

Relation to Patient: _____

Signature: _____

Date: _____

How you would like to be contacted? (Please Circle All That Apply)

Phone: Home _____ Work _____ Cell _____

Email: _____

Both

Please list the name(s) of anyone that has your permission to access information on the Patient Name* listed above:
(This information includes, but is not limited to: Treatment Completed & Required, Appointments, Account Balance, Insurance Information, etc.)

Name	Person's Relation to Patient	Your Initials