CHRISTY SAVAS, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability and 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, or as a result of a liability or worker's compensation claim.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below, I acknowledge that I have been offered/received a copy of Dr. Christy Savas, DDS Notice of Privacy Practice document.

Patient Name: _____D.O.B. _____

Signature: _____DATE: _____

Relationship to Patient: _____

Please list below the names, relationships, and phone numbers of any authorized individuals with whom we may discuss your medical or financial information. This permission will extend to making and verifying appointments, billing information, discussing test results, and general care with either the office staff and/or providers.

NAME RELATIONSHIP PHONE

_____

_____

_____

OFFICE USE ONLY

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:	Initials:	Reason: