

River Valley Oral and Maxillofacial Surgery, Ltd.

RVOMS

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Moline, Illinois 61265

(309) 797-1770

Business Office (309) 797-5633

Notice of Privacy Practices Acknowledgement

Fax (309) 797-1791

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:

- 1) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- 2) Obtain payment from third-party payers.
- 3) Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received 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 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: _____

*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: