WENDEL FAMILY DENTAL CENTRE
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 doctor 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 Wendel Family Dental Centre has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact them at any time at the Vancouver address below 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:____ Date: ___________________

Parent Name (if minor): ____

Patient/Parent Signature: ____

Relationship to Patient: □ Self □ Parent □ Other: _________________________________

I would like to give the following individuals authorization to discuss matters relating to my treatment and account. I understand without this consent, no one, other than myself, will be able to discuss these matters. This authorization will remain in effect until withdrawn by you in writing.

______________________________ Relationship to Patient: □ Spouse □ Parent □ Other: _________________________

______________________________ Relationship to Patient: □ Spouse □ Parent □ Other: _________________________

OFFICE USE ONLY

I attempted to obtain the patient's or legally authorized individual's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: