NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
DAMIAN D. BLUM D.M.D., P.A.

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), 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's certifications.

I understand the Act of 1996 and that under this act Dr. Blum and staff are required to abide by the policy that is stated in the HIPPA regulations. 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 or ask the staff at Dr. Blum office to provide me with 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.

Patients Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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: