NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

TRAFALGAR FAMILY DENTISTRY INC.

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 is 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 players.
- 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 descriptions 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 currant 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 treatments, 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_____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATIURE IN ACKNOWLEDGEMENT ON THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGE, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE:_____ INITIALS:_____

REASON_____