Smiles of Lombard, P.C.
845 S. Main St. Suite 201 Lombard IL 60148
Ph: 630-376-6176 Fax: 630-519-4184

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provide in detail the uses and disclosures on my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
- A description of uses and disclosures that are prohibited or materially limited by law
- A description f other uses and disclosures that will be made only with written authorization and that I may revoke such authorization
- My individual rights with respect to protect health information and brief description of how I my exercise these right in relation to:
  - The right to complain to this practice to the Secretary of DHHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the of such a complaint
  - The right to request restrictions on certain uses and disclosures of my protected health information and that this practice is not required to agree to a requested restriction
  - The right to receive confidential communications of protected health information
  - The right to inspect and copy protected health information
  - The right to amend protected health information
  - The right to receive an accounting of disclosures of protected health information
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request

I authorize Smiles of Lombard, PC to leave a message or send information regarding me personal health history, such as test results, physician/dentist messages, insurance or billing information or appointment information. **Please initial each line that you authorize**:

_____Telephone message _____Text message _____Email message
_____Mail to: □ Home ▣ Office Fax to: □ Home ■ Office Fax number: _____

This practice reserves the right to change the terms of this Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

_____ _____
Signature of Patient of Legal Guardian Date

_____ _____
Print Patient's Name Print Name of Legal Guardian (if applicable)