



Dr. Koko Papazian DDS
8930 Waukegan Rd. Ste.110
Morton Grove IL. 60053

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____ **Date of Birth:** _____

I have received this practice's Notice of privacy written in plain language. The Notice provides in detail the uses and disclosure of 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.
- The Type of uses and disclosure that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of each of the purposes for which this practice is permitted or required to use or disclose protected health information without a written consent or authorization.
- A description of other uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individuals rights with respect to protected health information and brief description of how I may exercise these rights in relation to:
 1. The right to complain to this practice and to the secretary of HHS if I believe my privacy rights has been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 2. 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 requested restriction.
 3. The right to receive confidential communications of protected health information.
 4. The right to inspect and copy protected health information.
 5. The right to amend protected health information
 6. The right to receive an accounting disclosure of protected health information.
 7. The right to obtain a paper copy of the Notice of Privacy Practices from the practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy 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: _____

Date: _____

Relationship to patient (if signed by personal representative of patient): _____