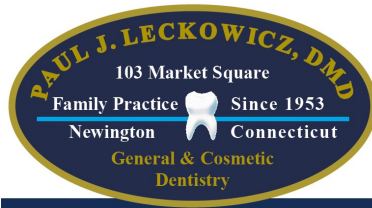


Notice of Privacy Practices Acknowledgement



Paul J. Leckowicz, D.M.D.
103 Market Square
Newington, CT 06111

I understand that, under the Health Insurance Portability & Accountability Act 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and we will use 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 certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description 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 current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing from you that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree that you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

Office Use Only

I attempted to obtain the patients signature in acknowledgement on the *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date:	Initials:	Reason: