

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* of Central California Dental Surgicenter. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

This notice is effective as of April 1, 2003 and we are required to abide by the terms of the *Notice of Privacy Practices* currently in effect.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting us at (209) 381-2047 /or/ writing us at 3605 Hospital Road Suite H, Atwater, CA 95301.

I acknowledge receipt of the *Notice of Privacy Policies* of Central California Dental Surgicenter.

Signature: _____ Date: _____
(patient /parent/conservator/guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of provider representative: _____
Date: _____

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services Office of Civil Rights
200 Independence Ave., S.W., Washington D.C. 20201
(202) 619-0257 or Toll Free 1-877-696-6775