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### NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this 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 or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received “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 and at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

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

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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#### OFFICE USE ONLY

DATE	INITIALS:	REASON:
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