

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

This acknowledgement confirms that you have received, reviewed, and understand the Notice of Privacy Practices (NPP) of this dental practice, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and applicable federal and state laws.

Dental Practice Name: Kopp Bloom Full

Effective NPP Date: February 16, 2026

Summary of HIPAA Privacy Rights

HIPAA is a federal law designed to protect the privacy and security of your protected health information (PHI). PHI includes information about your health condition, treatment, and payment for healthcare services that can identify you.

By signing below, you acknowledge that you understand:

- Your PHI may be used and disclosed for treatment, payment, and healthcare operations.
- Your PHI may be disclosed without authorization when required by law (e.g., public health, law enforcement, fraud prevention).
- Certain sensitive information, including substance use disorder-related records, may have additional confidentiality protections.
- You have the right to inspect, obtain copies of, and request amendments to your PHI.
- You have the right to request restrictions on certain uses or disclosures of your PHI.
- You have the right to request confidential communications by alternative means or locations.
- You have the right to receive a paper copy of the Notice of Privacy Practices upon request.
- You have the right to file a complaint if you believe your privacy rights have been violated, without retaliation.
- Uses or disclosures not described in the Notice generally require your written authorization.

Acknowledgement

I acknowledge that I have received a copy of the dental practice's Notice of Privacy Practices. I understand how my protected health information may be used and disclosed, and I understand my rights regarding my health information.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

If signed by a personal representative:

Representative Name: _____

Relationship to Patient: _____

For Office Use Only

If the patient refuses to sign this acknowledgement, document the reason below:

