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**OFFICE COPY**

**Notice of Privacy Practices Acknowledgment**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand this PHI can and will be used as outlined in the Notice of Privacy Practices that I have read.

I understand that this practice has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy at any time.

I understand that I may request in writing that this practice restrict how my PHI is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree with my restrictions, but if you do agree, then 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 acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date	Initials	Reason: