VIDAS CEMARKA DDS
office@cemarkadds.com

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been given the opportunity to review Notice of Privacy Practices for Dr. Cemarka's office. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that might occur in my treatment, payment for services and in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Dr. Cemarka's office reserves the rights to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change then I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective, I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

In the course of your treatment it may be necessary to share your protected health information with your spouse, family members and/ or doctors involved in your care. If there is anyone you DO NOT want to have access to this information please list it below:

______________________________ ______________________________

If you specifically would like us to be able to discuss all aspects of your care with someone please give them permission to speak with us below:

______________________________ ______________________________

Please feel free to contact us with any questions you may have about these policies and procedures.

Print Name:____

Signature:____________________________________Date:___________________