JOHN J KOZICKI D.D.S.

The **Health Insurance Portability and Accountability Act** and **Michigan Law** requires that this office comply with certain regulations. Part of this compliance is to notify you of this office's Privacy Practices. Our Privacy Policy is available upon request, and on our web site, (johnjkozickiddspc.com). We use your protected Health Information to obtain payment from your insurance company and to consult with specialists regarding your dental health. By signing this acknowledgement; you accept that you have been given the opportunity to review our policies, you have been informed of your rights under them and that you agree with them.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I, please print your name____________________________________,

have reviewed a copy of Dr. John Kozicki's Privacy Practices.

I agree, by signing below that the person(s) listed has my permission to discuss my protected health information with Dr. John Kozicki or his staff,

List person(s) here____

Date: _________________________

Signed ____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Privacy Practice however:

____ Individual refused to sign_____ An Emergency situation prevented signature

Date: _______________ Initials_____________