

# PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

AB Orthodontics, Inc.

Darrick A. Brown, D.M.D., M.D.S.

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## ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have been provided with a copy of the **Notice of Privacy Practices (NPP)** for **AB Orthodontics, Inc.**, effective **January 1, 2026**.

I understand that this Notice describes how my protected health information (PHI) may be used and disclosed, how I may access my information, and my rights regarding the privacy of my health information, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), as amended, and applicable federal and state law.

I understand that the Notice includes specific information regarding:

- My privacy rights under HIPAA
- How my dental and medical information may be used for treatment, payment, and health care operations
- Special privacy protections for certain sensitive information, including **substance use disorder records (42 CFR Part 2)** and **reproductive health information**
- How to file a complaint if I believe my privacy rights have been violated

I understand that **AB Orthodontics, Inc.** reserves the right to change its Notice of Privacy Practices and that a current copy will be available in the office, on the practice website (if applicable), and upon request.

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## PATIENT INFORMATION

Patient Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## PERSONAL REPRESENTATIVE (If Applicable)

If this acknowledgment is signed by a personal representative of the patient, please complete the following:

**Representative Name (Print):** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Representative Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## FOR OFFICE USE ONLY

If acknowledgment is not obtained:

Patient refused to sign acknowledgment

Patient unable to sign due to incapacity or emergency situation

**Reason (if applicable):** \_\_\_\_\_

**Staff Member Name / Initials:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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*This acknowledgment is maintained in the patient's record as required by HIPAA. Refusal to sign does not affect the patient's ability to receive treatment.*