TRENTON
IMPLANTS & DENTAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care);
- Obtaining payment from third party payers (ie. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices (which is also readily available at trentonimplants.com), which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected. The undersigned acknowledged receipt of a copy of the currently effective Notice of Privacy Policy for Trenton Implants and Dental Surgery, which is also located on trentonimplants.com. A copy of the signed, dated acknowledgement shall be as effective as the original.

Please print your name: _____

Please sign your name: _____

Signed this _____ day of _____ 20_____

*If you are a legal representative of the patient, please print the patient's name here and describe your authority: _____

Please list those who you authorize disclosing your personal information regarding visits at Trenton Implants and Dental Surgery. This can be revoked at any time.

1. _____ Relation: _____

2. _____ Relation: _____