Notice of Patient Privacy Practices Acknowledgement

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) defines the conditions under which we may use or disclose your protected health information. The law also provides you certain rights that are designed to protect your privacy. Your rights and the circumstances under which when may use your protected health information are outlined in our ***Notice of Privacy Practices***.

I acknowledge that I have read and/or received a copy of Christopher J Maestro, DMD, *FAGD's* ***Notice of Privacy Practices:***

____ _____________________

Signature of patient or authorized representative Date

____

Print name of patient or authorized representative

Please provide us with the names of those individuals who are involved in your care with whom we may share your protected information to coordinate your care.

____ _____________________

Name of individual involved in your care Relationship to you

____ _____________________

Name of individual involved in your care Relationship to you

____ _____________________

Name of individual involved in your care Relationship to you

You may share my information via: **VOICE MAIL** **EMAIL** **TEXT**

(Circle all that apply)

The individual was given the opportunity to read and/or receive a copy of our ***Notice of Privacy Practices*** but written acknowledgement could not be obtained because individual refused to do so.

Staff signature ______________________________ Date______________________________