Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES- CONSENT OF DISCLOSURE

Joseph D. Randazzo DDS
1544 Kuser Road, Suite C-3
Trenton, NJ 08619

PATIENT NAME: _____

I hereby give consent to Joseph Randazzo, DDS, LLC to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in restriction upon this request.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required if we do, the restriction will be obligatory to us.

Our posted Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted Policy before you sign this consent.

We reserve the right to amend the terms of our posted Policy.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly or indirectly

Obtain payment from third party payers

Conduct normal healthcare operations such as quality assessments and physician certifications

I have received and understand your *Notice of Privacy Practices and Consent for Disclosure* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices and Consent for Disclosure* from time to time and that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions,

Signature:_____ Date:_____
Patient or Representative

FOR CANCELLATION PURPOSES ONLY

I hereby void the consent given above

Signature:_____ Date:_____
Patient or Representative