ANTOINETTE MARIE TAUK, D.D.S., L.L.C.

Family and Cosmetic Dentistry

2050 State Highway 27, Suite 207
North Brunswick, NJ 08902
Telephone: (732) 940-0092

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

I , ____, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information
- My privacy rights with regard to my protected health information
- This office's obligations concerning the use and disclosure of my protected health information

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints relating to this office, I may contact:
Antoinette M. Tauk, DDS

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our *Notice of Privacy Practices* before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully before signing this Consent.

We reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we change our privacy practices, we will issue a revised *Notice of Privacy Practices*, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Information which may be disclosed:

- Appointment dates and times
- Treatment plans and referrals
- Financial and billing information
- Any other pertinent dental health information related to treatment at this office

Emailing X-Rays:
In providing the best treatment for our patient, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any

action we took in reliance on this Consent before we received your revocation, and we may decline to treat you or to continue treating you if you revoke this Consent.

I understand that this permission will remain in effect unless a written cancellation has been provided to Antoinette Marie Tauk, DDS, LLC.

SIGNATURES - PATIENT OR PERSONAL REPRESENTATIVE:

I , ____, have had full opportunity to read and consider the contents of this Consent form and your *Notice of Privacy Practices.* I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ____ Date: ____________________

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

Personal Representative's Name: ____
Print Name

Relationship to Patient:____

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*. In spite of our effort, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (*please check all that apply*):

☐ Patient refused to sign (date of refusal) ________________

☐ Communication barriers prohibited obtaining and acknowledgement

☐ An emergency situation prevented us from obtaining an acknowledgement

☐ Other *(please provide specific details):*

____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AFTER YOU SIGN IT

Include completed Consent form in the patient's chart.