Dudley Katz, D.D.S., P.C.

101 St. Claire Place

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PATIENT ACKNOWLEDGEMENT FORM

Use & Disclosure of Protected Health Information

Dudley Katz D.D.S., P.C. "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this office's *Notice of Privacy Practices* by initialing below:

X _____

Patient's/Parent's initials

Our *Notice of Privacy Practices* states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy by mail.

X _____

Patient's/Parent's initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

X _____

Patient's/Parent's initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

X _____

Signature and Date