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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

I acknowledge that I was provided with a copy of the Carol A. Horkowitz D.M.D Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Carol A. Horkowitz D.M.D continues in its good faith effort to comply with the requirements of the federal lprivacy law, I hereby consent to the use and disclosure of my health informationfor the purposes and activities permitted under the federal privacy law, and which are described in the Notice of Privacy Practices.

I understand that I should read the Notice of Privacy Practices carefully.

Signature _____ **Date** _____

AUTHORIZATION FOR COMMUNICATION

Our practice is dedicated to maintaining the privacy of your protected health information. In addition to the methods of communication and the messages we will leave for you that are described in our Notice of privacy Practices, which you have had an opportunity to review, please indicate below if you give authorization to Carol A. Horkowitz D.M.D.

E-mail treatment information to you. If yes e-mail address:_____ ◯ Yes ◯ No

Discuss your medical condition with another person.If yes with whom_____**Relationship**_____

◯ Yes ◯ No

Signature of patient, parent, or legal guardian (responsible party):

Signature _____ **Date** _____

Relationship to Patient:

Response Date: ____/____/_____