JERSEY CITY ORAL SURGERY
&
Dental Implant Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the office's Notice of Privacy Practices. Jersey City Oral Surgery & Dental Implant Center provides this form to comply with the HIPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, and healthcare operations.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print Name of Patient or Legally Authorized Representative Legal Relationship to Patient

I give permission for Jersey City Oral Surgery & Dental Implant Center to:

□ Call/leave message at my home telephone number: _____

□ Call/leave message/text on my mobile number: _____

□ Call/leave message on my work number: _____

□ Send me an unencrypted email: _____

□ Other:

_____

I give permission for you to speak with these individuals about my care:
(Note: Please notify us if you wish to make a change in the future.)

Name	Relationship	Phone Number

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ Office Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:

□ Patient/Representative refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please Specify): _____

Staff Initials: _____