Paul J. Mortiere & Robert C. Gasparotto, D.D.S., P.C.

Effective April 14, 2003, the federal law known as the Health Insurance Portability and Accountability Act 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. As of September 23, 2013, we are required to comply with government update to this policy known as The 2013 Final Rule.

To comply with one of the HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF OUR NOTICE OF PRIVACY PRACTICES.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

For office use only:

☐ Patient Refused to Sign.

☐ The following circumstances prohibit the patient from signing the Acknowledgement.

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☐ An emergency situation prevented the patent from signing the Acknowledgment.

____

Office Personnel (signature)

____

Office Personnel (print name)

Date:______________________________

____

Patient Name (please print)

____

Patient/Parent Signature

Date:______________________________

From time to time, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

PLEASE SIGN BELOW TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT IS DEEMED NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.

PATIENT CONSENT

I consent to your disclosure of my information, which you deem is necessary in connection with my treatment. I understand that such disclosure may not be of the type listed.

____

Patient Name (please print)

____

Patient/Parent Signature

Date:______________________________