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Notice of Privacy Practices Acknowledgement

Section A: Patient Information.

Name: _____ Telephone: _____
Address: _____

Section B: Acknowledgement and Consent.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the office's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review and keep a paper copy of the notice of Privacy Practices prior to signing this consent. Dr. Karen Altszuler reserves the right to revise her Notice of Privacy Practices at anytime, provided such applicable law permits the changes. Dr. Altszuler reserves the right to make the new terms of the Notice of Privacy Practices effective for all health information maintained, including health information created or received before the new terms become effective. Any revised notice will be posted in the office, and copies will be available there as well.

With my permission, the office of Dr. Altszuler may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment and recall reminders, insurance and billing items, and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Dr. Altszuelr may mail or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment and reminder postcards and sealed patient statements.

I have the right to request, in writing, that the office of Dr. Altszuler restrict how it uses and /or discloses my PHI. The practice is not required to agree to my requested restrictions if, for example, such restrictions would violate current state and federal law, or unreasonably impede the ability of the practice to carry out daily TPO. If the practice does agree to the requested restrictions, it is bound by this agreement.

By signing this, I consent to the office's use and disclosure of my PHI for TPO.
I have received a paper copy of this office's Privacy Practices Notice.

SIGNATURE: _____ **DATE** _____

If a personal representative, parent, or legal guardian signs this authorization on behalf of the individual, please complete the following:

Name of Representative, Parent, or legal guardian: _____

Relationship to Patient: _____