Joseph DiBenedetto, D.M.D.
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732-219-6744

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

" You May Refuse To Sign This Acknowledgement"

I have received a copy of the Notice of HIPAA Privacy for the Dental Practice

_________________________ ______ __________________________

Please Print Date Signature of Patient,Parent, Guardian

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the dental practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care. I wish to be contacted in the following manner. (check all that apply)

Home Telephone _____________
____OK to leave detailed message
____ Leave message with call back numbers

Written Communication
____OK to mail to home
____OK to mail to work

Work Telephone_____________
____OK to leave detailed message
____ Leave message with call back number

Fax Communication
____OK to fax to
this number____________

Other persons I designate as persons involved with my health care.

Name___________________ Number________________

Name___________________ Number________________

PRIVACY POLICY AVAILABLE UPON REQUEST