Robert E. Jepko D.D.S., PA

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT NAME:_____ DATE OF BIRTH: _____

Robert E. Jepko, DDS, PA reserves the right to release your healthcare information based upon the decision by Dr. Jepko for medical emergency situations and in general for continuity of care. We will release your information to third party payers in order to receive payment for services. We will use your healthcare information as needed to maintain our internal operations. We will release your information to anyone else that you may elect in writing to receive it. For continuity and quality of care, we may also receive information regarding your prescriptions from your pharmacy.

You have been offered a copy of our "Notice of Privacy Practices" that contains a complete description of the uses and disclosures covered under this consent. You have been given time to review the "Notice of Privacy Practices" and we have encouraged you to read it and ask any questions that you may have prior to signing this consent.

Our office reserves the right to change the privacy practices as stated in the "Notice of Privacy Practices". You will be given a copy of the revised notice with your first office visit following any change. The most current notice is prominently posted, and copies are available in our reception area.

You have the right to request that we restrict how your health information is used or disclosed. We are not required to agree to your requested restriction, but if we do agree to the restriction, we will honor the restriction.

You have the right to revoke this consent except to the extent that we have already taken action covered under the consent. If you choose to revoke this consent, you must do so in writing. Please understand that we will decline to treat you or continue to treat you if you revoke this consent.

AUTHORIZATION FOR RELEASE OF INFORMATION

DISCLOSURE OF INFORMATION/ FAMILY & FRIENDS:

With whom may we discuss the patient's health information? (please print)

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

NAME: _____ Relationship: _____

May we also disclose financial information? (circle one) Yes No

We reserve the right to contact you (call, email or text) regarding your appointment(s) and/or leave information on your answering machine / voicemail.

This consent must be signed by the patient and dated:

_____ _____

Signature of Patient or Responsible Party Relationship if Not Patient

_____ _____

Printed Name **Date**