John J. Tortora D.D.S

Dentistry *www.HolisticSmilesNJ.com*

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to our use of your protected health information to carry out treatment, payment activities, and healthcare operations.
NOTICE OF PRIVACY PRACTICES: You have the right to read our Notice of Privacy Practices before you decide to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we may maintain.

You may obtain a copy of our Notice of Privacy practices, including any revisions of our Notice, at any time by contacting: John J. Tortora, D.D.S

PHONE: (732) 295-1616 FAX: (732) 295-1616
EMAIL: TORTORAOFFICE@GMAIL.COM
ADDRESS: 2095 Hwy 88, Brick, NJ 08724

RIGHT TO REVOKE: You will have the right to revoke this consent at any time by giving us written notice of revocation submitted to the contact person listed. Please note that this revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or continue treating you if you revoke this Consent.

I, ________________________________, have had full opportunity to read and consider the form. I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and healthcare operations.

SIGNATURE: ____ DATE: ________________________

* If this Consent is signed by a person representative on behalf of the patient, complete the following:
Personal Representative's NAME: ___________________________________
Relationship to Patient: ____________________ Date: _________________

PHOTOGRAPHIC REPRESENTATION: Please sign if you allow Dr. Tortora to use your photos publicly, for teaching purposes or to represent the practices completed service.
PATIENT SIGNATURE: ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT

I have received a copy of this office's Notice of Privacy Practices.

I ____
(Please Print Name)

____
(Please Sign Name)

____
(Please Date)

For Office Use Only

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

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Specify): ____

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2095 Hwy. 88 • Brick, NJ 08724 • (732) 295-1616 • Fax (732) 892-3570

Tortoraoffice@gmail.com • www.HolisticSmilesNJ.com