
Jason P. Tosto, DMD

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ have read the HIPAA Notice of Privacy Practices. I understand how my health information may be used and disclosed to third parties only for the purposes of providing treatment, obtaining payment and conducting health care operations. I understand that a paper copy of this notice may be provided to me at my request.

Patient Signature _____ Date _____

-----**FOR OFFICE USE ONLY**-----

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because _____

Employee Name _____ Signature _____

Date _____