NOTICE of PRIVACY PRACTICES  
PATIENT ACKNOWLEDGEMENT

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Philip E. Memoli DMD, FAGD  
438 Springfield Avenue  
Berkeley Heights, NJ 07922  
908 464-0144 | 908 464-1137 FAX  
Dr.Memoli@systemicdentistry.org

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**Name of Patient Date of Birth**

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**I have received this practice’s *Notice of Privacy Practices* written in plain language. The *Notice* provides in detail the  
uses and disclosures of my protected health information that may be made by this practice, my individual rights and  
the practice’s legal duties with respect to my protected health information. The *Notice* includes:**

* A statement that this practice is required by law to maintain the privacy of protected health information
* A statement that this practice is required to abide by the terms of the *Notice* currently in effect
* Types of uses and disclosures that this practice is permitted to make for each of the following purposes:  
  treatment, payment and health care operations
* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization
* A description of uses and disclosures that will be made only with my written authorization and that I may revoke such authorization
* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
* The right to complain to this practice and to the Secretary of HHS\* if I believe my privacy rights have  
  been violated, and that no retaliatory actions will be used against me in the event of such a complaint
* The right to request restrictions on certain uses and disclosures of my protected health information,  
  and that this practice is not required to agree to a requested restriction
* The right to receive confidential communications of protected health information
* The right to inspect and copy protected health information
* The right to amend protected health information
* The right to receive an accounting of disclosures of protected health information
* The right to obtain a paper copy of the *Notice of Privacy Practices* from this practice upon request

This practice reserves the right to change the terms of its *Notice of Privacy Practices* and to make new provisions  
effective for all protected health information that it maintains. I understand that I can obtain this practice’s current  
*Notice of Privacy Practices* on request.

\**The U.S. Dept. of Health and Human Services*

**CHOOSE OPTION A or B**

🞏 Option A| **LIMITED DISCLOSURE** 🞏 Option B| **NO DISCLOSURE  
 (you must choose this option if you have dental insurance)**

**I allow the practice to submit the information necessary to  
file insurance claims or to contact the doctors listed below:**

DOCTORS

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Signature Date**

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**Name of Minor (if parent or guardian)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_