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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand under the Health Insurance Portability & Accountability Act of (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used by to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or enclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my request restrictions but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____