NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Dr. Alejandro Castaño
16 Pocono Rd, Suite 213
Denville, NJ 07834

I, , understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

> Conduct, plan and direct my treatment and follow-up among the multiple health-care providers who may be involved in that treatment directly and individually. Obtain payment from third-party payers. Conduct normal health-care operations such as quality assessments, dentist certifications, request x-rays, records and reports.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of any 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 receive a current copy of the *Notice of Privacy Practices*.

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

Patient or Legal Guardian Signature _____ Date _____

Authorization to Release Information:

I, , hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professional, information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluation and administering claims for benefits.

Patient or Authorized Guardian's Signature _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity.

Signed (Insured Person) _____ Date _____