MARIA E. CARDENAS D.M.D., P.C.
DBA MARIA CARDENAS DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

NOTICE OF PRIVACY PRACTICES: With this form you have been provided with a copy of our Notice of Privacy Practices which provides a full description of how we will use an disclose your individually identifiable health information, including uses and disclosures for treatment, payment, and health care operation purposes. This Notice also explains important rights you have regarding your health information. Maria Cardenas D.M.D. hereinafter referred to as the "Practice") reserves the right to change its Privacy Notice at any time but you may always obtain a copy upon request.

USE AND DISCLOSURE OF INFORMATION: As described in our Notice of Privacy Practices, we will use and disclose your individually identifiable health information for a variety of treatment, payment and health care operations purposes. Such disclosure of your information may be made via mail, telephone, fax, e-mail, and/ or Internet as may be necessary for the Practice to complete these purposes. If your health information contains any privileged or additionally protected information under State or Federal law you will be asked to sign a specific authorization for the release of this information.

RESTRICTIONS ON USES AND DISCLOSURES: As explained in our Notice of Privacy Practices, you have the right to request how the Practice uses and discloses your health information for the purposes of treatment, payment and heath care operations and disclosures to family members or friends. You also have the right to ask us to send communications including your health information to an address of your choice or that we communicate with you a certain way (e.g. do not leave messages on my home answering machine). While we are not required to grant any such request, you may indicate your desired restrictions or instructions here:

_____
_____
_____

I hereby give consent to the Practice, and its professionals, employees and agents, to use and disclose my individually identifiable health information as described above. I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices. I hereby release Practice, its professionals, employees and agents, from all liability arising from the use and disclosure of my health information for treatment, payment and operations purposes. I understand that I have the right to revoke this consent at any time. I understand that if I revoke this consent, I must do so in writing and present it to the Practice. I understand that the revocation will not apply to information that has already been released pursuant to this consent. I understand that if I revoke this consent, the Practice may refuse to provide me with further treatment.

I also understand that this consent authorizes the Practice to use and disclose all past information documented in my medical record in accordance with its Privacy Notice.

_____ _____ _____
Patient/Guardian Relationship Date

TO BE FILLED OUT IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM PATIENT

On _____/____/_____, I attempted to obtain a written acknowledgement of receipt of the Practice Notice of Privacy Practices from the above named patient, but was unable to because:

Check the appropriate box:

Patient declined to sign the Written Acknowledgment..

Other (specify details**)**_____

By:
_____

_____ Date :_____
Name and Title of Employee