JANSEN WOO, D.D.S, P.C.
FÏ €F ÔŠŒÜÒÞÖUÞÁŠXÖ., SUITE GG€
ARLINGTON, VA GGG€J

Acknowledgement of Receipt of Notice of Privacy Practices – HIPAA & Consent for Use and Disclosure of Health Information

Name: ____ Date of Birth: _______________

My signature below confirms the following:

I have received a copy of the *Notice of Privacy Practices*.

I consent that, under certain circumstances, this office may use and disclose my health information as described in the *Notice of Privacy Practices* for treatment, payment, and health care operations.

This includes my consent for this office to perform the following:

i) To use my name for laboratory work
ii) To use my Social Security Number only as required by my insurance company; or other appropriate people; and/or in the case of non-payment, a collection agency or attorney
iii) To discuss, as part of conducting health care operations, my health care and personal information with other healthcare providers, laboratory technicians, insurance companies, or other appropriate people, and/or in the case of nonpayment, a collection agency or attorney
iv) To leave appointment information by such means as voice-mail, electronic-mail, postcards, verbal messages given to a family member, or other person answering home or work telephone
v) To leave or request other information (Ex. Insurance information, clinical diagnoses) by such means as voice-mail, electronic-mail, verbal messages given to a family member or other designated individuals

Please print the names of family members and or other designated individuals with whom we may disclose health care information. Write "None", if you do not permit this office to discuss any information with anyone except you and those mentioned in the *Notice of Privacy Practices*.

Names: ____ Relationship: ______________

I acknowledge that while on the premises, I may request discussion of my personal health information in a private area of the office,

I acknowledge that I may revoke my consent to the above at any time by notifying Dr. Woo in writing. Upon revoking my consent, Dr. Woo reserves the right to refuse treating me as a patient of this practice.

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Signature of Patient or Legal Guardian Date