ROY C. BLAKE, III, D.D.S., M.S.D.

Cosmetic, Reconstructive & Dental Implants Specialist
MAXILLOFACIAL PROSTHODONTIST

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

BY SIGNING BELOW, 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 my personal information will only be disclosed in the following circumstances:

- to conduct, plan, and direct my treatment and follow-up among healthcare providers (my named doctors or alternate dentist) who may be involved in my treatment directly and indirectly.

- to obtain payment to be paid to me from third party payers (such as my insurance company) as per my request.

BY SIGNING BELOW, I grant Dr. Blake, his staff, and his associates permission to leave a message on my home answering machine, cell phone, and/or call me at my place of work unless I direct them not to do so in writing.

BY SIGNING BELOW, I acknowledge that a copy of the HIPPA Policy is available to me upon request.

_____
Print Name

_____
Signature

_____
Today's Date

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT **

OFFICE USE ONLY

We attempted to obtain the patient's signature in consent of this Notice of Privacy Practices Acknowledgement, but we were unable to do so as documented below.

Date: _____ Initials: _____ Reason: _____

200 BUTLER STREET, SUITE 203 ~ WEST PALM BEACH, FL 33407
200 CENTRAL BOULEVARD, SUITE A ~ JUPITER, FL 33458
PHONE: 561-296-3399 ~ FAX: 561-282-0833
EMAIL: ROYBLAKEDDS@GMAIL.COM