Jeffrey S. Bilotti, D.D.S., P.A.

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Jeffrey S. Bilotti, D.D.S., P.A. I hereby authorize as indicated by my signature below, Jeffrey S. Bilotti, D.D.S., P.A. to use and to disclose my protected health information for any necessary clinical, financial and insurance purpose, as authorized in the Patient Consent Form.

____________________________ ____________________________

Print Name Address

____________________________ _____________

Signature (Legal Guardian) Date

Please list your preferred means of communication:

You may contact me at my home telephone number ____________________
You may contact me on my mobile telephone number ____________________
Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ______________________________________Date Added/Removed
2. ______________________________________Date Added/Removed
3. ______________________________________Date Added/Removed
4. ______________________________________Date Added/Removed