



Acknowledgment of Receipt of Notice of Privacy Practices

Last Name: _____ First: _____ Birthdate: _____

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that this facility reserves the right to change their Notice of Privacy Practices and that I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement.

I authorize Palm Beach Periodontics to SEND UNENCRYPTED PATIENT INFORMATION BY EMAIL AND OTHER ELECTRONIC MEANS

patient information relating to my treatment, medical status, or payment by email or other electronic means to me, someone I designate, health care plans, and/or other health care providers involved in my treatment. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

Patient or Legal Guardian: _____ Date: _____