ANCHOR
PERIODONTICS
Periodontal & Implant Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices. By signing this form, you consent to our use and disclosure of your protected health insurance to carry out treatment, insurance claims, payment activities and healthcare operations. You will have the right to revoke this consent at any time by submitting to our office written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating if you revoke this consent.

Indicated below are names of any Person(s) to whom I would like Drs. Tomaselli & Krishna to allow disclosure of individually identifiable Health Information Health Information (IIHI). Please specify the type of information that may be disclosed or you may indicate "All" if appropriate:

NAME	RELATION	ALLOWED DISCLOSURE	TELEPHONE

PRINTED NAME: _____

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- **Individual refused to sign**
- **Communications barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us from obtaining acknowledgement**
- **Other (Please Specify): _____**

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATIONS

I agree that the dental practice may communicate with me electronically at the email address below. I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I am responsible for providing the dental practice any updates to my email address. I can withdraw my consent to electronic communications by sending written notice to our office.

Email Address (Please Print Clearly):

_____ @ _____

Signature:_____ Date: _____

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