**GAITHERSBURG DENTAL ASSOCIATES**
8 Russell Avenue, Suite 104
Gaithersburg, MD 20877

# NOTICE OF PRIVACY PRACTICES

## USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION AGREEMENT

This disclosure contains information regarding the privacy of your personal healthcare information. Please read it carefully before signing.

By signing this disclosure, I acknowledge that Gaithersburg Dental Associates may use or disclose my protected health information for the purpose of carrying out treatment, billing and obtaining payment for services rendered, and healthcare activities. I understand that Gaithersburg Dental Associates may disclose my health information to other healthcare providers, dentists, and specialist for the same reasons. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and that the information may not be protected by Federal health information privacy laws.

Further, by signing this document I acknowledge that I have been provided a copy of and have read the Gaithersburg Dental Associates Notice of Privacy Practices containing description of my rights, and the permitted uses and disclosure, under HIPAA.

***Acknowledged and agreed to by:***

| Patient or Guardian's Name | Signature | Date |
|---|---|---|

Please list contact information at which you prefer to be reached and check the ones you *DO NOT* want us to leave message(s) regarding your protected health information.

| O Home Phone | O Mobile Phone | O Work Phone | O Email Address |
|---|---|---|---|

Notwithstanding the above paragraphs, the Federal Government now restricts health care providers from discussing your health information and condition with other persons or family members unless you specifically give your written permission. If you decide later that you do not want us to share this information any more, you can revoke this authorization at any time by giving written notice to Gaithersburg Dental Associates at the above address.

***By my signature above, I also grant Gaithersburg Dental Associates permission to discuss my protected medical information with the following individual(s):***

| Authorized Person's Name | Relationship | Phone Number |
|---|---|---|
| Authorized Person's Name | Relationship | Phone Number |
| Authorized Person's Name | Relationship | Phone Number |