Authorization/Acknowledgement

HIPPA: Acknowledgement of Receipt of Notice of Privacy Practices:

1. I have received and/ or been given the opportunity to receive a copy of Dr. Ilcheon Joo DDS Notice of Privacy Practices.

HIPPA: Consent for Use and Disclosure of Health Information:

(Notice of Privacy Practices: You have the right to read this practice's Notice of Privacy Practices before you decide to sign the consent). Our Notice of Privacy Practices provides a description of our treatment payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information and of the other important matters about your protected health information. A copy of our Notice accompanies the consent upon request. Please read this Notice prior to signing the consent. This practice reserves the right to changes the privacy practices as described in our Notice of Privacy Practice. If changes are made, a revised Notice of Privacy Practices containing the modifications will be issues. These changes apply to any of your health information that we maintain on file. You may obtain a copy of our Notice of Privacy Practices, including revisions of our Notice at any time. You have a right to revoke this consent for use and disclosure of health information at any time by giving us a written notice of your revocation and submitting it to the office manager of the practice.

1. I have had the opportunity to review and obtain a copy of this practice's Notice of Privacy Practices; I hereby authorize, by my signature below, to use and disclose my protected health information to carry out treatment payment activities and health care operations.

Signatures below indicate that I have read this entire document and fully understand the contents of this Authorization/Acknowledgement. I have been provided with the opportunity to ask questions and obtain further clarifications.

_____ _____

Signature of Patient/Guardian Date

List the names of anyone we can release your information to:

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