

Notice of Privacy Practices for Protected Health Information

Associated Oral Surgeons, P. A.

I acknowledge that I have been provided with the Notice of Privacy Practices for Protected Health Information. This notice explains how:

- Associated Oral Surgeons will only use my health information for the purposes of treatment, payment for my treatment and Associated Oral Surgeon's health care operation.
- This notice will also explain in more detail how Associated Oral Surgeons will only use and share my health information for other than treatment, payment and health care operations.
- Associated Oral Surgeons will only use and share my health information as required/permitted by law.

Patient's complete legal name: _____
(Please print)

Patient's SSN: _____ Patient's DOB: _____

Signature: _____ Date: _____
(Patient of legally authorized representative)

Relationship of legally authorized representative to patient: _