

Patient Consent / Acknowledgement Form

By signing below, you consent to the use and disclosure of your protected health information by Thomas Cholankeril DDS, our staff and business associates for treatment, payment and healthcare operations. For a more detailed description uses and disclosers for these purposes, please review our notice of privacy practices. You have the right to review our notice prior to signing this consent. The terms of this notice may change. If the terms do change, you may obtain a revised notice by simply contacting this office at 718.994.6200, and requesting a revised notice. We will also post any revised notice in this office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and healthcare operations. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your protected health information.

This form is also used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand, and agree to the consent of the notice of Privacy.

Patient Signature

Date

Patient Name

Date