# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
# MAZZELLA FAMILY AND COSMETIC DENTISRY

I understand that under the Health Insurance Portability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a complete description of the uses and disclosures of my health information. I understand that Mazzella Family and Cosmetic Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Mazzella Family and Cosmetic Dentistry at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment and health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient(s) Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____

**IF ANYONE <u>SHOULD NOT</u> HAVE ACCESS TO THE PATIENT'S MEDICAL OR FINANCIAL INFORMATION, PLEASE STATE THEIR NAME(S) HERE:**

Name: _____ Date: _____

Name: _____ Date: _____

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**OFFICE USE ONLY**

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

| Date | Initials | Reason |
|---|---|---|
| | | |

WALTER M.
MAZZELLA, D.D.S.
FAMILY & COSMETIC DENTISTRY

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Fax: 410.203.2546
**MazzellaDental.com**

## Patient Photo Release Form

I_____, hereby authorize Walter M. Mazzella, D.D. S. or any of his employees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, etc.).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

____I do not mind if my photographs are used in any of the above stated situations.

____I only agree to have my teeth shown without any identifying features.

Signed_____ Date _____