FREDERICK J. MARRA D.M.D.P.L.L.C
100 MAIN STREET
COHOES, NEW YORK 12047
518 237-0019
518 237-5461 (FAX)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT AUTHORIZATION FORM

I_____, have seen the posted copy of this office's notice of privacy practices. By signing this authorization, I authorize Dr. Marra's office to use and/or disclose certain protected health information about me or for the party or parties listed below. This authorization permits Dr. Marra's office to use or disclose to_____ the following individually identifiable health information (specifically describe the information to be released, such as dates of service, level of detail to be released, origin of information, etc.

_____

_____

This authorization permits Dr. Marra's office to contact me about appointments, return calls to me, test results, fax information, etc. at:

___home phone ___work phone ____leave message on answering machine
___cell phone ___leave message on cell or work voicemail ____leave message with a person to call office ____other_____
____email messages and appointments ___text messages

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPPA privacy rule. I have the right to revoke this authorization in writing except to the extent that Dr. Marra's office has acted in reliance upon this authorization. My written revocation must be submitted to Dr. Marra's privacy officer at the above address.

Signed by_____ _____
Signature of patient or guardian Relationship to patient

Patient's Name_____ Date _____

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign_____ Communication barriers prohibited obtaining the acknowledgement_____
Other_____