GREGORY B. JERLINGA, DDS, SC
759 SOUTH SAINT AUGUSTINE STREET
PULASKI, WI 54162-0380

Notice of Privacy Practices Acknowledgement

By signing this form, you will consent to our use and disclosure of your protected health information (PHI) for the following purposes:

- To conduct and plan treatment, including multiple healthcare providers who may be involved in treatment directly or indirectly
- To obtain payment for services provided to you through third-party payers
- To conduct normal healthcare operations such as quality assessments, ect.

I have received/been offered a copy of the above-named office's Notice of Privacy Practices (NOPP) containing a detailed description of the uses and disclosures of my PHI.

We reserve the right to change our privacy practices as described in our NOPP. If we change our privacy practices, we will issue a revised NOPP, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

I understand that I have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and this office's NOPP. I understand that, by signing this consent, I am giving my consent to your use and disclosure of my PHI to carry out treatment, payment activities, and health care operations.

____
Print name

____
Patient or Guardian signature   Date

OFFICE USE ONLY

______ Individual Refused to Sign

____
Signature of Office Manager   Date