Mark I. Gutt, D.M.D., P.A.
975 Arthur Godfrey Rd. #304 Miami Beach, FL 33140 305-538-2112
21110 Biscayne Blvd. #305 Aventura, FL 33180 305-932-1887

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
and
CONSENT FOR RELEASE OF MEDICAL RECORDS AND USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, ___________________, acknowledge receipt and/or review of a copy of the currently effective Notice of Privacy Practices (NOPP) and hereby authorize Mark I. Gutt, D.M.D. P.A. and its staff (hereafter collectively referred to as "Practice") to use and disclose verbally, by mail, fax or unencrypted e-mail my entire medical record as needed, including super-confidential information as stated in the NOPP, such as (initial where applicable) ___HIV records (including HIV test results) and sexually transmissible diseases, ___alcohol and substance abuse diagnosis and treatment records, and/or ___psychotherapy records, in accordance with the NOPP.

The purpose of the Acknowledgement is to document our good faith effort to obtain an acknowledgement of receipt of the NOPP. You may refuse to sign this Acknowledgement.

The purpose of this Consent is to give us your consent for our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Example of use of health information for treatment purposes includes discussing your treatment with another practitioner (e.g. - your referring dentist) to obtain treatment input.
Example of use of health information for payment purposes includes communication with your insurance company regarding your treatment benefits.
Example of use of health information for healthcare operations include sharing information about you with other business associates that provide services such as quality assessment and improvement, outcome evaluation, protocol and clinical guideline development, training programs, credentialing, medical/dental review, legal services and insurance.

I have reviewed the NOPP, been given an opportunity to ask questions about it, understand it and do hereby agree to its terms. A copy of this signed, dated Acknowledgement and Consent shall be as effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent. You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Practice.

FOR ACKNOWLEDGEMENT:
By Patient:____ Date____________
(Print name and sign)
Or
By Patient's Representative:_________________________________ Date:____________
(Print name, sign, and describe authority)

FOR CONSENT:
By Patient:____ Date:____________
(Print name and sign)
Or
By Patient's Representative:_________________________________ Date:____________
(Print name, sign, and describe authority)

COMPLETE AS APPLICABLE WITH REGARD TO MY RECORDS:
1. Please send a copy of my records (including information from other health-care providers that it may contain) to _______________________________ at _______________________________. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law.
2. Please allow ____________________ to pick up a copy of my records (including information from other healthcare providers that it may contain). The copies will be ready on_________________.
3. I acknowledge I will be charged copying costs in the amount of ________.