ROBERT N. BURSTEIN, D.D.S.

PATIENT CONSENT/ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Robert N. Burstein, D.D.S., our staff, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures 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 the Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting our privacy contact, Rosemary Sousa, at 860-644-4741 and requesting a revised Notice. We will also post any revised Notice of Privacy Practices in the reception area.

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 health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, You may refuse to consent to the 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 (PHI).

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 CONTENT OF THE NOTICE OF PRIVACY.

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Name of Patient(s) - Please Print

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SIGNATURE OF PATIENT DATE

If not signed by patient, please indicate your relationship to the patient______________________

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For Office Use Only

☐ **Signed form received by:** ______________________

☐ **Acknowledgement/consent refused:**

Efforts to obtain: ______________________

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Reasons for refusal: ______________________

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Robert N. Burstein, D.D.S.
Effective April 14, 2003
(033103)