ELI ABBO, D.M.D., P.A.
3031 NE 163rd Street
North Miami Beach, FL 33160

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES BEFORE SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF ELI ABBO, D.M.D., PA. NOTICE OF PRIVACY PRACTICES.

With my consent **Eli Abbo, D.M.D., P.A.** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **Eli Abbo, D.M.D., P.A.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

Eli Abbo, D.M.D., P.A. Reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **Eli Abbo, D.M.D., P.A.**
3031 NE 163rd Street, North Miami Beach, FL 33160.

With my consent, **Eli Abbo, D.M.D., P.A.** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, **Eli Abbo, D.M.D., P.A.** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

With my consent, **Eli Abbo, D.M.D., P.A.** may disclose my information for purposes of internal staff training or for external educational uses. For example, the doctor may use my health information as part of an academic seminar to demonstrate treatment techniques.

With my consent **Eli Abbo, D.M.D., P.A.** may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Eli Abbo, D.M.D., P.A.** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Eli Abbo, D.M.D., P.A.** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Eli Abbo, D.M.D., P.A.** may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

Patient's Name

____
Print Name of Patient or Legal Guardian

____
Date

Good faith attempt to obtain the signature from the patient; Describe the reason why patient did not sign the form:
____
____
____

____
Signature of the Staff Member

____
Name of the Staff Member

____
Date