

*Smile* CENTRAL

**NICOLAS AVALOS, D.M.D., P.A.**

**34 S.W. DOUGLAS ROAD**

**CORAL GABLES, FL. 33134**

**PHONE: 305 446-6900 FAX: 305 446 9096**

**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 PRIOR TO SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF NICOLAS AVALOS, D.M.D., P.A. NOTICE OF PRIVACY PRACTICES.**

With my consent **NICOLAS AVALOS, 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 **NICOLAS AVALOS, D.M.D., P.A.** Notice of Privacy Practices for a more complete description of such uses and disclosures.

**NICOLAS AVALOS, D.M.D., P.A.** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **NICOLAS AVALOS, D.M.D., P.A. 34 S.W. DOUGLAS ROAD. CORAL GABLES, FL 33134 - (305) 446- 6900**

With my consent, **NICOLAS AVALOS, 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, **NICOLAS AVALOS, 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, **NICOLAS AVALOS, D.M.D., P.A.** may e-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. I have the right to request that **NICOLAS AVALOS, 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 **NICOLAS AVALOS, 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, **NICOLAS AVALOS, D.M.D., P.A.** may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

Date: \_\_\_\_\_

\_\_\_\_\_  
Print Patient's Name

\_\_\_\_\_  
Print Name of Legal Guardian or Representative

\_\_\_\_\_  
Relationship to Patient

**NAME(S) OF PRIVACY OFFICER(S):** Esperanza Avalos/Annette Cardoso at above address and telephone number