Drs. Oghalai, Krutoy and Toscano
Privacy Notice & Release of Information

PATIENT NAME: _____

PRIVACY NOTICE:

I have had the opportunity to review Drs. Oghalai, Krutoy and Toscano Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law. I understand the contents of this Notice.
Drs. Oghalai, Krutoy and Toscano understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your protected health information is kept private.

May we leave a message on the numbers you have provided? ____***Yes*** ____***No***
May we leave a message with a family member? ____***Yes*** ____***No***

RELEASE OF INFORMATION

I authorize the release of information including: diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

( ) Name _____ Relationship: _____Phone: _____

( ) Name _____ Relationship: _____ Phone: _____

( ) Information is not to be released to anyone.

The **Release of Information** will remain in effect until terminated by me in writing.

By signing below, I acknowledge that I have read and understand the above information.

__X_____ _X_____
Patient Signature (or Guardian if under 18) Date

If not signed by the patient, please indicate the relationship to the patient.

Relationship _____

INTERNAL USE ONLY

If the patient or patient's representative refuses to sign this acknowledgement of receipt of the NOTICE, please document the date and time the NOTICE was presented to the patient and sign below.

Presented on: _____ (DATE) _____ (TIME) Presented by: _____ (Staff)

OPIOID EDUCATION

My signature below acknowledges that I have been given opioid education material. I have had the opportunity to read and understand the information provided to me and my questions have been answered:

__**X**_____ _**X**_____
Signature Date

PATIENT PHOTOGRAPHY RELEASE

I grant Drs. Oghalai, Krutoy and Toscano permission to take and use digital images and/or videos of me for the purpose of: dental records, dental research, dental education (i.e. lectures, seminars, demonstration, professional publications), marketing (i.e. patient education, brochures, website, social media). I understand that if the digital images and/or videos are used, my name or other personal identifying information will be kept confidential.

__**X**_____ _**x**_____
Signature Date

_____ (Staff Initials)