



# A to Z Family Dentistry, PC

Marina Guelfguat, D.D.S.

159 E. Main Street  
Little Falls, NJ 07424

Tel: (973) 837-6655  
Fax: (973) 837-6654

Email: [atozfamilydentistrynj@gmail.com](mailto:atozfamilydentistrynj@gmail.com)  
Website: [atozfamilydentistrynj.com](http://atozfamilydentistrynj.com)

---

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### Health Insurance Portability Accountability Act (HIPAA), 1996

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You may obtain a copy of our Notice of Privacy Practices at any time by contacting: Dr. Marina Guelfguat, A to Z Family Dentistry, PC 159 E. Main St., Little Falls, NJ 07424 (973)837-6655.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

\*You may refuse to sign this Acknowledgment.

Patient's Printed Name: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

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

If a personal representative on behalf of the patient signs this Consent, complete below:

Representative's Printed Name: \_\_\_\_\_

Representative's Signature: \_\_\_\_\_

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

---

### For Official Use Only

We attempted to obtain written acknowledgement or receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) \_\_\_\_\_