

**Plaza Medical and Diagnostic, P.C.**  
**752 Park Avenue**  
**Huntington, NY 11743**

**Receipt of Privacy Notice (HIPAA)**

I have been presented with a copy of Plaza Medical and Diagnostic, P.C.'s Notice of Practice Policies, detailing how my information may be used and disclosed as permitted under Federal and State law. I understand the contents of the notice, and I request the following restriction(s) concerning the use of my personal medical information:

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Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

I grant Plaza Medical and Diagnostic, P.C. the permission to use and disclose my Protect Health Information to the following people:

Referring Doctor: \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

Dentist: \_\_\_\_\_

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

If not signed by patient, please indicate relationship to patient (e.g., spouse, parent, etc.)

Relationship: \_\_\_\_\_ Witnessed by: \_\_\_\_\_

Internal use only:

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

Presented on (date and time): \_\_\_\_\_

By (name and title): \_\_\_\_\_