DR. NEIL HOSS, DMD, LLC

115 Hartford Turnpike | Tolland, CT 06084

HIPAA Notice of Privacy Practices

Patient Acknowledgment and Authorization Form

Original effective date: December 22, 2020 | Revised notice effective date: 11/12/2026

IMPORTANT: This summary describes how your protected health information may be used and disclosed, and your privacy rights. Please review the practice's complete Notice of Privacy Practices.

1. Our Commitment to Your Privacy

Dr. Neil Hoss, DMD, LLC is committed to protecting the confidentiality of your dental and health information in accordance with HIPAA and applicable Connecticut law.

2. Uses and Disclosures

Treatment: We may share relevant information with dental specialists, laboratories, physicians, and other providers involved in your care.

Payment: We may use or disclose information to verify insurance, submit claims, process payments, and manage billing.

Healthcare Operations: We may use information for quality assurance, training, compliance, licensing, and administration.

Appointment Communications: We may contact you about appointments, follow-up care, and treatment-related matters.

3. Disclosures Permitted or Required by Law

We may disclose information without written authorization where permitted or required by law, including certain public-health reporting, suspected abuse or neglect, legal proceedings, law-enforcement requests, and serious threats to health or safety. Applicable legal safeguards and limitations apply.

4. Your Privacy Rights

Subject to applicable exceptions, you may request access to or copies of records, amendments, restrictions, confidential communications, an accounting of certain disclosures, and a paper copy of the complete notice. You may file a privacy complaint without retaliation.

5. Changes to Privacy Practices

The practice may revise its privacy practices and notice as permitted by law. The current notice will be made available to patients.

6. Acknowledgment of Receipt

I acknowledge that I have received or been offered a copy of Dr. Neil Hoss, DMD, LLC's Notice of Privacy Practices (HIPAA Privacy Policy). Please check one option below. Signing this acknowledgment does not waive any of my privacy rights.

☐ I received a copy of the Notice of Privacy Practices.
☐ I was offered a copy of the Notice of Privacy Practices.

Patient name (print): _____

Patient / representative signature: _____

Date: _____

Representative relationship or authority (if applicable):

_____

Authorization to Discuss or Disclose Health Information

Additional Persons Authorized to Receive or Discuss My Health Information

I authorize Dr. Neil Hoss, DMD, LLC and its authorized staff to discuss or disclose my protected health information with the people identified below, including dental treatment, appointments, treatment plans, billing, insurance, and related matters, except as limited below.

Authorized Individual 1

Full name: _____

Relationship: _____

Phone number: _____

Authorized Individual 2

Full name: _____

Relationship: _____

Phone number: _____

Authorized Individual 3

Full name: _____

Relationship: _____

Phone number: _____

Authorized Individual 4

Full name: _____

Relationship: _____

Phone number: _____

Limitations or Restrictions

_____

_____

Authorization Terms

• This authorization is voluntary. Treatment and payment for treatment generally are not conditioned on signing it.

• I may revoke this authorization in writing at any time, except to the extent action has already been taken in reliance on it.

• Information disclosed to an authorized individual may be redisclosed by that person and may no longer be protected by HIPAA.

• This authorization does not limit disclosures otherwise permitted or required by law.

Expiration date or event: _____

Patient Authorization

I have read and understand this authorization and authorize the disclosures described above.

Patient name (print): _____

Patient / representative signature: _____

Date: _____

Representative relationship or authority (if applicable):

_____