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**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE**

You may refuse to sign this acknowledgement

I have been informed of your Notice of Privacy of Practice containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practice from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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