LANCASTER DENTAL ASSOCIATES, P.C.

Acknowledgment of Receipt of Notice of Privacy Policies And Consent for Disclosure for Treatment, Payment and Operations.

We are required by law to provide our patients with a copy of our Privacy Notice.

ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

____
(Signature of patient or legal guardian)

____
(Print name and relationship)

____
(Date)

Office Use Only

We attempted to obtain written acknowledgment of receipt/consent of our Notice of Privacy Practices but acknowledgement/consent could not be obtained for the following reason:

Individual refused to sign

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

____

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Initial: _______

Update 1/01/09