Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of the Lyssa A Reed D.D.S. INC. Notice of Privacy Practices.

_____[Please Print Name]

_____[Signature]

_____[Date]

If this Acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name

Relationship to Patient _____

For Program Use Only

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

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

Consent Form for Use or Disclosure of Patient Health Information

I authorize *Lyssa A. Reed, D.D.S., INC* to use or to disclose to _____ the health information of _____ for the purpose of _____.

I understand the receiving party may not further disclose this health information without first obtaining a new written authorization from me. I understand this authorization may be cancelled or modified at any time upon provision of a written notice to this dental practice. I understand that I may refuse to sign this authorization; and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits. I understand I may have a copy of this authorization.

The health information to be used or disclosed is limited to the following: *(you may note dates, procedures, or use other description)*

_____

_____

This authorization is valid until: _____

Signature: _____

Print name: _____

Date Signed: _____

Signed by: ☐ Patient ☐ Parent/legal guardian☐ Personal representative of the patient -- *describe the legal authority that permits the representation:*