ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

CONSENT FOR USE AND DISCLOSURE OF HEATLH INFORMATION

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Barry H. Stevens, D.D.S., P.A., on this_______day of _________________, 20___

A copy of this signed, dated Acknowledgement / Consent shall be as effective as the original.

____

Please print your name

____

Please sign your name

If you are the legal representative of the patient, please print the patient's name (s) and describe your authority

____

I authorize ____as my personal representative and to whom I give consent to disclose personal healthcare information, including treatment, payment and /or healthcare operations.

Signature____

You may refuse to sign this acknowledgement

Office use only

As privacy Official, I attempted to obtain the patient's (or representative's) signature on this acknowledgement but did not because:

It was emergency treatment ___
I could not communicate with the patient ___
The patient refused to sign ___
The patient was unable to sign (please describe) ___

____

Signature of privacy official__________________________ Date:______________________