Monte Morgan DMD

Privacy Practices Acknowledgment and Health Information Consent

FORM 101 / R220209

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether or not to sign this consent. A copy of our notice and/or this consent is available upon request. Our notice provides a description of our treatment, payment activities, and healthcare operations, and of the uses and disclosures we make of your protected health information.

PURPOSE OF CONSENT

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and operations.

ACKNOWLEDGMENT

I have been offered a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

PATIENT SIGNATURE (PARENT / LEGAL GUARDIAN IF MINOR) _____ DATE ____/____/_____

PATIENT NAME _____

PARENT / LEGAL GUARDIAN NAME (IF NOT PATIENT) _____ RELATIONSHIP _____

OFFICE USE ONLY

Attempt was made to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained due to the following reason:

- ◯ Individual refused to sign
- ◯ Communication barriers prohibited obtaining the acknowledgment
- ◯ Other (specify) _____

DATE

INITIALS