

PLEASE READ, SIGN AND RETURN THIS FORM PRIOR TO BEING TREATED

Doctors Clark & Lester
Family & Cosmetic Dentistry
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100 Heatherbrooke Park Drive
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION

Acknowledgement of Receipt: I have received a copy of this office's Notice of Privacy Practices and I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 as set out in the Notice.

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 healthcare operations as set out in the attached "Notice of Privacy Practices" and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed in our Notice of Privacy Practices. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline ☐ to treat you or to continue treating you if you revoke this Consent.

I, _____, Date of Birth: _____,
PRINT NAME OF PATIENT of Patient

have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. 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 as set out in the Notice.

Signature: _____ Date Signed: _____

If signed by a parent, guardian or personal representative on behalf of the patient, complete the following:

Parent, Guardian or
Personal Representative's Name: _____
Relationship to Patient: _____
PLEASE PRINT NAME

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices and Consent for the Use and Disclosure of Health Information, but we could not obtain because:

- _____ Individual refused to sign
- _____ Communications barriers prohibited obtaining the acknowledgement and consent
- _____ An emergency situation prevented us from obtaining acknowledgement and consent
- _____ Other: _____

Initials of Employee _____

THIS FORM MUST REMAIN IN OUTSIDE POCKET OF PATIENT'S CHART