JASON GORDON DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided **JASON GORDON DDS** Notice of Privacy Practices ("Notice"):

- It tells me how **JASON GORDON DDS** will use my health information for the purposes of my treatment, payment for my treatment, and health care operations.
- The Notice explains in more detail how he may use and share my health information for other than treatment, payment, and health care operations.
- **JASON GORDON DDS** will also use and share my health information as required/permitted by law.

Patient's Complete Legal Name: _____

(please print)

Patient's DOB _____ Date: _____

Signature: **X** _____

(Patient or legal representative*)

*May be requested to show proof of representative status