

# LANCASTER DENTAL ASSOCIATES, P.C.

## Acknowledgment of Receipt of Notice of Privacy Policies And Consent for Disclosure for Treatment, Payment and Operations.

*We are required by law to provide our patients with a copy of our Privacy Notice.*

### ACKNOWLEDGMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

\_\_\_\_\_  
(Signature of patient or legal guardian)

\_\_\_\_\_  
(Print name and relationship)

\_\_\_\_\_  
(Date)

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### Office Use Only

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We attempted to obtain written acknowledgment of receipt/consent of our Notice of Privacy Practices but acknowledgement/consent could not be obtained for the following reason:

Individual refused to sign

Communication barriers prohibited obtaining acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_

Initial: \_\_\_\_\_