WARNER FAMILY DENTISTRY, LLC
Lindsey H. Warner, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving acknowledgement and consent

Name:____

Address:____

Phone:_____________________________________ E-mail:__________________________________

SS#:______________________________________ DOB:____________________________________

Section B: To the patient – please read the following statements carefully

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

Notice of Privacy Practices: By your consent, you are acknowledging receipt of Notice of our Privacy Policies that describe our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we make changes, we will issue a revised Notice to make you aware.

Right to Revoke: You have the right to revoke Consent at any time by giving us written notice of your revocation to our office. Please understand that revocation of the 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.

SIGNATURE:

I have fully read and considered the contents of this acknowledgement and consent form and the Notice of Privacy Practices from this office. I understand that by signing this 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.

Signature:____ Date:________________

(Patient/Parent/Guardian/Responsible Party)