LONG ISLAND PROSTHODONTICS

ACKNOWLEDGEMENT AND CONSENT

You May Refuse to Sign This Acknowledgement and Consent

By signing below, I hereby acknowledge that I have reviewed a copy of this office's Notice of Privacy Practices and have therefore been advice of ow 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 ad described in the Notice.

_____

Signature of the Patient or Personal Representative

_____

Print Name of the Patient or Personal Representative (including description of legal authority)

_____

Date

_____

Witness

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Practice, but acknowledgement could not be obtained because

- ☐ Individual refuse to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)