

Gregory Lane, D.M.D.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

PRINT NAME: _____

SIGNATURE: _____ DATE: _____

Based on the new privacy laws I hereby give my consent for this office to use my health information for treatment, payment and healthcare operations. You have my permission to send appointment reminder calls, leave voice messages at my home regarding appointment confirmations or to speak to adult family members regarding insurance information. You may discuss my health information with other healthcare providers as deemed necessary. I also consent to the use of photographs for the purpose of documenting my treatment progress or for the aid of explaining treatment options to other patients, provided my name is NOT used.

SIGNATURE: _____ DATE: _____

- You may refuse to sign this document.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgment

An emergency situation prevented us from obtaining acknowledgment

Other: _____