LIFETIME DENTAL CARE
DR. JAMES Y. CHEN

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

PATIENT CONSENT

Sometimes it is necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist, health care professional or dental laboratory, or otherwise make disclosures of your information in connection with coordinating your treatment. Please sign below to consent to our disclosures of your information that we consider necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you consider are necessary in connection with my treatment.

I have received, have been offered a copy of this office's Notice of Privacy Practices or the Privacy Practices have been explained to me.

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(Patient's Name – Please Print)

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(Patient's Signature – Parent/Guardian if patient is a minor)

____

(Date)

For Office Use Only

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

____ Individual refused to sign

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify) ________________________________