Dr. Lamont B Jacobs Orthodontics Inc.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I______________________________________, have received a copy of this office's Notice of Privacy Practices.
(PRINT NAME)

Please print names of dependants (under age 18) who are/ will be patients, and your relationship.

______________________________	______________________
(NAME)	(RELATIONSHIP)
______________________________	______________________
(NAME)	(RELATIONSHIP)

☐ You also consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health operations.

______________________________	______________
(SIGNATURE)	(DATE)

Right to revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to our office. Please understand that revocation of this 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.

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other