ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

LAKESIDE DENTAL – Benjamin D. Bushnell, DDS, PC

You may refuse to sign this acknowledgement but, in refusing, we will not be able to process your insurance claims.

I acknowledge that I have received a copy of Lakeside Dental's Notice of Privacy Practices. I understand that this notice describes how Lakeside Dental (Benjamin D. Bushnell, DDS, PC) may use and disclose my Protected Health Information.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHE R ATTENDING DOCTORS IN THE FUTURE.

Patient's Printed Name: _____

Patient's Signature: _____ Date: ___/___/___

If signed by the patient's personal representative, indicate below:

Name of Signer: _____

Relationship to Patient: _____

PLEASE LIST ANY OTHER PEOPLE WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

This includes spouse, partner, parents/step-parents (when patient is over age 18), grandparents and any care takers who can have access to this patient's records.

NAME: _____ NAME: _____

NAME: _____ NAME: _____

NAME: _____ NAME: _____

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

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify)

_____
_____
_____