NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEGEMENT

I have received this practices' Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my information.
I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information initiated and/or controlled by this practice. I understand I can obtain the practice's current Notice of Privacy Practices on written request.

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by Lincoln Way Family Dental in order to carry out treatment, payment, or health care operations. The patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health information at any time. If the Facility does change the terms of its Notice of Privacy Practices, patient may obtain a copy of the revised Notice by making a request in writing.

Patient retains the right to request that the Facility restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions, however, if the Facility does agree to the patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, patient retains the right to revoke this consent. Such revocation must be submitted to the Facility in writing. The revocations shall be effective except to the extent that the Facility has already taken action in reliance on the consent.

The Facility may refuse to treat patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).

I have read and understand this information and I am the patient or am authorized to act on behalf of the patient to sign this document verifying consent to the above stated terms.

Printed Name _____ **Date** _____

Signature of Patient_____ **Date** _____

Parent/Guardian _____ **Date** _____