ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE

I acknowledge receipt of the Privacy Practice of Deer Ridge Family Dental and acknowledged that I have had the opportunity to read this description of their Privacy Practices and asked question regarding their privacy practice.

___________________________________ ___________________________________

Patients Name (PLEASE PRINT) Patients Signature or Legal Representative

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Date Signed

DATE: ____________________ Dr Joseph J. Sipin D.D.S.,/Dr Rochelle Manangkil D.D.S (Privacy Officer/Contact Person)

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Having read and understood the Privacy Practices of Deer Ridge Family Dental, I hereby consent for use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

I understand that I am not required to give this consent in order for Doctor's to use my protected health information for treatment, payment activities and healthcare operations. I also understand that I may revoke this consent in writing by submitting the revocation to the Privacy Officer/Contact Person listed on the officer's Privacy Practice notice. I further understand that if I decline to give my consent or if I revoke it, Doctor's, may refuse to treat me or proceed with treatment, payment activities and health care activities as if consent was given or not revoked.

___________________________________ ___________________________________

Patients Name (PLEASE PRINT) Patients Signature or Legal Representative

____

Date Signed

The Patient, ___________________________________, was provided a copy of this Consent use and Disclose Protected Health Information and has either been unable to sign or refused to sign it.

REVOCATION OF CONSENT

I hereby revoke the consent for ____________________________, to use protected health information, which I gave on _____/_____/______ (Today's Date). I understand that Doctor's, may refuse to treat me or may proceed with treatment, payment activities and healthcare operations as if this revocation was not made.

__________________________________ __________________________________

Patients Name (PLEASE PRINT) Patients Signature or Legal Representative

____

Date Signed