Acknowledgement Of Receipt
Of
Notice Of Privacy Practices

I, ____ have received a copy of

(Name Of Patient)

Amanda R. Trotter D.D.S.

____ Notice of Privacy Practices.

____

(Signature Of Parent)

Staff Will Fill Out This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason:

______ Patient refused to sign.

______ Emergency situation kept us from obtaining the patient's signature.

______ Language barriers kept us from obtaining the patient's signature.

______ Other____

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of written notice of my privacy rights and I consent to AMANDA TROTTER, DDS using and disclosing my protected health information to carry out treatment, payment, or health care operations.

I understand and have been provided with a *Notice of Privacy Practices*, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior signing this consent.

I understand that AMANDA TROTTER, DDS reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request AMANDA TROTTER, DDS c/o AMANDA TROTTER, DDS, 211 OLD HEWITT RD, WACO, TX 76712.

I understand that I have the right to restrict how AMANDA TROTTER, DDS uses or discloses my protected health information to carry out treatment, payment or health care operations; that AMANDA TROTTER, DDS is not required to agree to the restrictions and; that AMANDA TROTTER, DDS is bound by restrictions to which it agrees.

I request the following restrictions to how my health information is used or disclosed:

____

____

____

____

____

____

I have the right to revoke this consent by notifying AMANDA TROTTER, DDS in writing, except to the extent that AMANDA TROTTER, DDS has taken action in reliance on my consent.

______________________________________ Signature of patient or patient's representative	________________________ Date
______________________________________ Printed name of patient or patient's representative	________________________ Relationship to patient or representative's authority to act for the patient