Concord & Lexington Oral Surgery Associates
Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Concord & Lexington Oral Surgery Associates. I hereby authorize, as indicated by my signature below, Concord & Lexington Oral Surgery Associates to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

______________________________ ______________________________
Print Name Address

______________________________ __________
Signature Date

Please check your preferred means of communication:

☐ You may contact/leave a message for me at my home telephone number
____

☐ You may contact/leave a message for me on my mobile telephone number
____

☐ You may contact/leave a message for me on my work telephone number
____

☐ You may send me an unencrypted email/text message at: ______________________

☐ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____ Date Added / Removed: _________

2. ____ Date Added / Removed: _________

3. ____ Date Added / Removed: _________

4. ____ Date Added / Removed: _________

* * *

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) ____________________________________

Staff Person Initials __________