Central Park West Dental

David M. Shipper, DMD & Howard J. Vogel, DDS

Acknowledgement of Receipt of Notice of Privacy Policies and Consent for Disclosure for Treatment, Payment and Operations

By signing below, I hereby acknowledge that I have been provided with a copy of this office's *Notice of Privacy Practices* and have therefore been advised of how my protected health information may be used and disclosed by the office, and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities, and healthcare operations of the office as described in the Notice.

_____

Print Name of Patient or Personal Representative (including description of legal authority)

_____

Signature of the Patient or Personal Representative

_____

Date

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)