Crofton Dental Suites
2191 Defense Highway, Ste. 210
Crofton MD 21114
(410)721-2610 email: croftondentalsuite@gmail.com

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES
Written Acknowledgement Form

Notice to Patient:
We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse this acknowledgement, if you wish.

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of **treatment**, various activities associated with **payment** and **health care operations**. Our **Notice of Privacy Practices** provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

Crofton Dental Suites reserves the right to change their **Notice of Privacy Practices**. If we should do so, we will post a revised Notice. Since revisions may apply to your health care information, you have the right to receive a copy by contacting our Privacy Officer.

You have the right to **revoke** your consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this consent we may decline to treat you.

You are entitled to a copy of this consent after you have signed it.

I,_____, acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name Relationship to Patient

FOR OFFICE USE ONLY

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

□ Individual refused to sign

□ Communication barrier prohibited obtaining the acknowledgement.

□ An emergency situation prevented us from obtaining acknowledgement

□ Others (Please provide specific details)

_____

_____

_____ _____
Employee Signature Date

Our Privacy Officer can be contacted as follows:

Marilyn Fulton
2191 Defense Highway, Suite 210, Crofton MD 21114
(410)721-2610 or email: mfulton1206@gmail.com