ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Name of Patient:_____

I, (please print)_____**have received a copy of this office's Notice of Privacy Practices.**

_____ _____

Signature of Parent/Guardian/Patient (if of legal age) **Date**

(Please check EITHER the "Consent" OR the "Denial" below.)

☐ **CONSENT** (I have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of the protected health information of the above-named patient to carry out treatment, payment activities, and healthcare operations.)

☐ **DENIAL OF CONSENT** (I deny consent for your use and disclosure of the protected health information for treatment, payment activities, and healthcare operation for the above-named patient. I understand that denial of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Denial. I also understand that you may decline treatment or may not continue to treat the above-named patient.)