ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the American Dental Association "Notice of Privacy Practices":

- It tells me how Dr. Jonathan Bayne will use my health information for the purposes of my treatment, payment for my treatment, and health care operations.
- The Notice also explains in more detail how Dr. Jonathan Bayne may use and share my health information for other than treatment, payment, and health care operations.
- Dr. Jonathan Bayne will also use and share my health information as required/permitted by law.
- I understand that if I want no other persons other than myself to have access to my health care information that I must inform Dr. Jonathan Bayne, in writing, to this effect (forms available).

Patient's Complete Legal Name: _____
(please print)

Signature: _____ Date: _____
(Patient or Legally Authorized Representative)

Relationship of Legally Authorized Representative to Patient: _____