# ORAL SURGERY ASSOCIATES

## Acknowledgement of Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this consent.

Signed By: _____

Printed Name - Patient or Guardian

Relationship to Patient: _____
(if other than patient)

Signature:_____

Date: _____