ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

Dr. James Helsabeck, DDS

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Dr. James Helsabeck, DDS** "NOTICE OF PRIVACY PRACTICES", revision date March 23, 2013.

As required by the Privacy Regulations, ________________ from **Dr. James Helsabeck, DDS** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.

As required by the Privacy Regulations, I am aware that **Dr. James Helsabeck, DDS** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

- ☐ I wish to file a "Request for Restriction" of my Protected Health Information.
- ☐ I wish to file a "Request for Alternative Communications" of my Protected Health Information.

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I understand that this office is not required to honor any changes to the "Notice of Privacy Practices".

I have read "NOTICE OF PRIVACY PRACTICES" and understand my rights contained in the notice. By way of my signature, I provide Dr. James Helsabeck, DDS with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

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Patient's Name (Printed)

______________________________ ______________

Patient's Signature *Date*

______________________________ ______________

Authorized Facility Signature or Parent/Guardian if Minor *Date*