**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT TO USE AND DISCLOSURE FOR TREATMENT, PAYMENT AND OPERATIONS PURPOSES**

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

_____

Print Name of Patient

_____

Signature of Patient or Personal Representative (parent or guardian)

_____

Print Name of Personal Rep. (including description of legal authority)

_____

Date