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ORAL AND MAXILLOFACIAL SURGERY - PERIODONTICS
5350 East Main Street • Columbus, Ohio 43213

ACKNOWLEDGEMENT AND CONSENT PRIVACY PRACTICES

Yes ☐ I would like to receive a copy of the Notice of Privacy Practices.
(Please ask receptionist for a copy)

No ☐ I do not wish to take a copy of the Notice of Privacy Practices at this time.

We take our patients privacy very seriously in this office and we will not disclose any information without your consent.

Do you give permission for our office to discuss your health history or any medical concerns with anyone other than yourself?

☐ YES ☐ NO

If yes, please list the individual(s) and their relationship to you.

Name(s): _____Relationship_____

Name(s): _____Relationship_____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please Specify)