ORAL HEALTH CENTER of DELAWARE
AESTHETIC & SPECIAL CARE ASSOCIATES
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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our **Notice of Privacy Practices** before you decide whether to sign this consent. Our Notice Provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important maters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice Practices. If we change our privacy practices, we will issue a revised **Notice of Privacy Practices**, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

I have received and read a copy of Oral Health Center of Delaware's Notice of Privacy Practices:

_____
Patient Name

X_____ _____
Signature Date

_____
Print Name (If Parent/Guardian)