LANCASTER SMILES

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Notice of Privacy Practices

Patient acknowledgement of understanding

I hereby acknowledge that I understand the Notice of Privacy practices of Lancaster Smiles as required by Federal Law. The Notice explains my rights to protection of my personal health information and how this information may be used and distributed to other health care personnel as needed for the care of my oral health. I understand that my health information is protected by Federal Law and that by virtue of the business of dentistry some or all of my health information may be disclosed to other services as the practice deems necessary.

I understand that Lancaster Smiles reserves the right to change the terms of the Notice of Privacy Practices and to make changes regarding all protected health information contained in my record which is located and controlled by this practice. I understand that may obtain a copy of the current Notice of Privacy Practices upon request. We will use your addresses, emails, texts, and phone numbers of record to contact you unless you specify otherwise.

Please list any family members or people that we may discuss your dental care with if necessary

	Name	Relationship	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

This information will be considered current and valid unless you complete a new form and change this information in writing.

Signature of Patient or Guardian (over 18 years old) _____

Print Name of Patient _____Date _____

For office use only

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