The Practice of Dr. Stuart A. Greene

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: These forms, Notice of Privacy Practices and Acknowledgement of Receipt, presents the information that federal law requires us to give our patients regarding our privacy practices. We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

Please read the enclosed Notice of Privacy Practices form and keep for your records. **Please complete this form and return to our office. Dr. Stuart A. Greene, 2009 Birdcreek Terrace, Temple, TX 76502. If you have any questions you can call our office at (254) 773-9007.**

I, _____, have had full opportunity to read and consider the contents of this form and your Notice of Privacy Practices. I understand that, by signing this Acknowledgement, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and dental health care operations.

_____ _____

Please Print Name Signature Date

If this Acknowledgement is signed by a personal representative/guardian/parent on behalf of the patient, complete the following:

Personal Representative/Guardian/Parent's Name: _____

Relationship to Patient: _____

Minor's Name: _____ Date of Birth: _____

Minor's Name: _____ Date of Birth: _____

Minor's Name: _____ Date of Birth: _____

Minor's Name: _____ Date of Birth: _____

You may refuse to sign this acknowledgement

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and dental health care operations.

Signature: _____ Date: _____