PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Print Patient's Name _____ Date_____

I,_____, acknowledge that

(Signature of Patient or Parent or Legal Guardian)

I have received a copy of this office's NOTICE OF PRIVACY PRACTICES or that this office's NOTICE OF PRIVACY PRACTICES was made available to me to receive.

I,_____ , consent to the use and disclosure of my

(Signature of Patient or Parent or Legal Guardian)

personal health information by your office for Treatment, Billing/Payment and Healthcare Operations as outlined in the NOTICE OF PRIVACY PRACTICES.

General Informed Consent

I, _____, consent to necessary diagnostic or preventive treatment provided by Dr. Poon/Gong/Rivera including, but not limited to, diagnostic tests, cleanings, X-rays, exams, and any other procedure that is deemed necessary.

_____
Patient Signature

_____
Date