THE Center
for oral & maxillofacial surgery

Chad P. Collins, D.M.D.
Diplomate of the American Board of Oral & Maxillofacial Surgery

NOTICE OF PRIVACY PRACTICES-ACKNOWLEDGEMENT

You may refuse to sign this acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting the privacy officer for this office.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge being informed of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed name (if signed on behalf of the patient) Relationship
(Parent, legal guardian, personal representative)

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
___ Communication barriers prohibited the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify) _____
_____

This form will be retained in your medical record. Last update: ___/___/___

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