ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I have received a copy of J. Keller Vernon's, D.D.S., LTD's Notice of Privacy Practices.

Signature: _____ Date: _____

Printed Name: _____

SIGN BELOW ONLY; IF YOU WISH TO REVOKE YOUR CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date _____

For Office Use Only

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

Individual refused to sign: ____ Other _____

Communication barriers prohibited obtaining
the acknowledgment ____

An emergency situation prevented us
From obtaining acknowledgement ____

Disclosures of Protected Health Information for other than treatment, payment activities, and healthcare operations.

Date: _____ Protected Health Information Disclosed

Basis for Disclosure _____

For multiple disclosures to single person/entity for single purpose, frequency, and date of last disclosure for accounting period.