Dr. James Dean Jensen, D.D.S., M.S.D., P.A.

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information including but not limited to:

Permission to release our patient records and treatment information to any specialist or insurance company that is involved in your care.

Discussion of treatment between doctor and staff

Your signature also gives us permission to hand you an appointment reminder and send you correspondence by mail, and to remind you of appointments via telephone, postcard, or electronic media.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICY

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{Please Print Name – Guardian if a minor}

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{Signature}

____

{Date}

You May Refuse to Sign This Acknowledgement

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)____