

HARRIS PERIODONTICS & IMPLANT DENTISTRY

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have had the opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that by signing this consent I am giving my permission to use and disclosure of my protected health information to carry out treatment, payment activities including insurance claims, and healthcare operations including communication with your healthcare providers as specified in the Notice of Privacy Practices.

Patients Name: _____ Date: _____

Parent/Legal Guardian Name: _____

Signature of Patient or Parent/Guardian _____