Notice of Privacy Practices Acknowledgement and Consent

LINDNER DENTAL ASSOCIATES, P.C.

By signing below, I acknowledge that I have been provided a copy of the Lindner Dental Associates, PC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the dental practice listed at the beginning of this Notice, and how I may obtain access to and control of this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my dental care, to seek and receive payment for services given to me, and for the business operations of the dental practice, its staff, and its business associates.

_____ _____

Name of Patient **Date of Birth**

_____

Signature of Patient or Personal Representative

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

_____

Date