Dr. Dennis R. Lucas, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
YOU MAY REFUSE TO SIGN

I, _____ (Print Name), have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature **Date**

_____ I DO NOT give Dr. Dennis R. Lucas, D.M.D. permission to leave detailed messages on my answering machine/voicemail regarding dental appointments, treatments and pre-medication.

_____ I DO give Dr. Dennis R. Lucas, D.M.D. permission to leave detailed messages on my answering machine/voicemail regarding dental appointments, treatments and pre-medication. The following phone number should be called:

_____
Phone Number

Whom may we release both your medical & account information to: (Parents, Spouse, Siblings, Grandparents, etc…)? Please be specific:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

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 obtaining the acknowledgement
____ Emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify) _____

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P: 239-262-5851 F: 239-262-7498