ACKNOWLEDGMENT OF RECEIPT OF DR. JUSTIN JONES, D.D.S., P.A. (“P.A”)

NOTICE OF PRIVACY PRACTICES (“NOTICE”)

This office will not release any information without patient consent, unless disclosure is required by law, a legal process or governmental agencies.

Any complaints you may have pertaining to the security of your information should be directed to this office.

I have read the above notice and have had any questions answered by PA. I understand that by my signing this form, I consent to the sharing of information as stated in the Notice. My consent is freely given. I understand that I may revoke this consent at any time if the revocation is in writing, but any disclosures given prior are permissible.

Patient’s Name (printed)   Date

Patient’s Signature (or guardian, if minor)   Date