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Livonia Dental Care

Quality Family Dentistry

www.livoniadentalcare.com

**ACKNOWLEDGEMENT & CONSENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

I, (Patients' Name) _____, have been offered a copy of and understand the scope of this office's Notice of Privacy Practices. I consent my information, which you deem necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature _____

Date _____

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) _____