MIAMI SHORES DENTAL GROUP

OMAR F. OSMAN, D.D.S.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices And Consent to Use and Disclose Information

I acknowledge that I was provided with a copy of Omar Osman, D.D.S.' Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that Omar Osman, D.D.S. continues to its good faith effort to comply with the requirements of the federal privacy law, I hereby consent to the use and disclosure of my health Information for the purpose s and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling Omar Osman, D.D.S.' office at (305) 754-0062.

I acknowledge that I have received a copy of Omar Osman, D.D.S.' Notice of Privacy practices.

_____ _____
Patient Name (Please Print) Date

_____
Signature of Patient

_____
Patient Legal Representative (if applicable)

_____ _____
Signature of Legal Representative Date

FOR DENTAL OFFICE USE ONLY

_____
Office Staff Member Obtaining Signature

Reason signature and date were not obtained:

- **Individual refused to sign**
- **Communication barriers prohibited obtaining the acknowledgement**
- **An emergency situation prevented us form obtaining acknowledgement**
- **Other (please specify)** _____