James R. Seligman D.M.D.
1180 Washington Street Suite 102 Boston,
MA 02118

Your Privacy is Important to Us

I hereby acknowledge that a copy of the Notice of Privacy Practice of Seligman Dental Designs has been made available to me. I hereby authorize, as indicated by my signature below, to use and to disclose, my protected health information for any necessary clinical, financial, and insurance purposes, as authorized by the Patient Consent Form.

* You may refuse to sign this acknowledgement *

____________________________________ ____________________________________
Patient Name Address

____________________________________ ________________
Signature of Patient (or Legal Guardian) Date

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) such as parents, or other family members or friends. (For minors, please list anyone we can speak with other than the custodial parents or legal guardians.)

Name_____________________ Phone #_____________________ Date added/removed________________

Name_____________________ Phone #_____________________ Date added/removed________________

Name_____________________ Phone #_____________________ Date added/removed________________

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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
- An emergency situation prevented us from obtaining the acknowledgement
- Other