CD Pennsylvania Dental, P.C., dba
DRS. MELMAN, RAVETT & ASSOCIATES
6012 Greene Street
Philadelphia, PA 19144

ACKNOWLEDGEMENT RECEIPT NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Notice of Privacy Practices for **Drs. Melman, Ravett & Associates.** The Notice of Privacy Practices describes the types of uses and disclosure of my protected health information that might occur in my treatment, payment for services, or in the performance of the office health care operations. The Notice of Privacy Practices also describe my rights and the responsibilities and duties of CORDENTAL Group with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Drs. Melman, Ravett & Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ YES	☐ NO
SPOUSE/PARTNER ONLY	☐ YES	☐ NO
OTHER (PLEASE SPECIFY) _____	☐ YES	☐ NO

MY SIGNATURE BELOW ACKNOWLEDGES I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES. ALL OF MY QUESTIONS HAVE BEEN ANSWERED AND I UNDERSTAND THAT I MAY MAKE INQUIRY TO THIS ACKNOWLEDGEMENT AND/OR CHANGES IN THE ADDITIONAL DICLOSURE AUTHORITY AT ANY TIME.

_____ _____
PATIENT NAME (PRINTED) DATE

_____ _____
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE RELATIONSHIP TO PATIENT

OFFICE USE ONLY: RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

ACKNOWLEDGEMENT WAS NOT OBTAINED FOR THE FOLLOWING REASON(S):

☐ Needed more time to review Notice of Privacy Practices.
☐ Wanted to consult with another person before signing.
☐ Unable to sign.
☐ Reason not given
☐ Other (please explain) _____

_____ _____
PATIENT NAME (PRINTED) DATE

_____ _____
CORDENTAL GROUP REPRESENTATIVE POSITION