LEE DENTAL ASSOCIATES
Elbert M. Lee, D.M.D. & Travis A. Thompson, D.M.D.

HIPPA

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Lee Dental Associates Notice of Privacy Practices. By signing below, I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____
Patient Name (Type or Print) Date

_____
Signature

By signing below, I am giving Lee Dental Associates permission to discuss my treatment, appointments and financial issues with the following people:

_____

_____

_____

_____ _____
Signature Date

SAVE PRINT SUBMIT