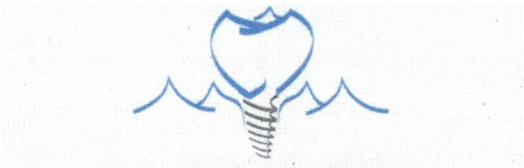

ROCKY MOUNTAIN DENTAL
Family Dentistry
Dental Implant Center
2475 Wadsworth Blvd.
Lakewood, CO 80214

Acknowledgement of Receipt of Privacy Practices And Consent/Limited Authorization & Release Form

You may refuse to sign this acknowledgement but, in refusing we will not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Rocky Mountain Dental Group. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

Patient Full Legal Name: _____

1. What Name I prefer to be called: _____
2. How I like to get routine messages – please check all that apply
   Letter _____Email_____Phone_____Fax_____

3. Where is it ok to leave a message about my dental health – check all that apply.

   Never_____Home_____Mobile_____Work_____

4. Please list any other parties who can have access to your dental information
   No One _____
   Name:_____Relationship:_____ Phone:_____
   Name:_____ Relationship:_____ Phone:_____
   Name:_____ Relationship:_____ Phone:_____

_____ _____

Signature of Patient or authorized representative Date

Verification of photo ID _____ Verified By:_____