ACKNOWLEDGMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I (patient name)_____have received a copy of the office's Notice of Privacy Practices. I give my permission to Dr. Howard Sommers and staff to speak with:_____

Signature: _____ Date: _____

We attempted to obtain written acknowledgement of receipt of our 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 acknowledgement
- ☐ Other (Please Specify)

CONSENT TO USE

Of photograph, Likeness, Picture, Name, Comments, Testimonial, or Voice by Howard Sommers DDS.

I (patient name) _____do hereby fully and freely consent to use, by Howard Sommers DDS, and/or its agents and assigns of my photograph, picture, name, comments, testimonial, and/or promotion or advocacy of Dr. Howard Sommers DDS.

I do here release and hold harmless Howard Sommers DDS and/or its agents and assigns from any liability with regard to the above stated purposes arising out of said consent to use. I hereby grant to Howard Sommers and/or its agents and assigns the right to use my photograph or likeness, picture, name, comments, testimonial, and/or voice to advertise and publicize the interests of Howard Sommers DDS.

Signature of Patient:_____ Date: _____

If patient is a minor, Signature of Parent:_____ Date: _____

Signature of Witness:_____ Date: _____