

MICHAEL LUM, D.D.S., INC
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I, _____, understand that as part of my healthcare, *Michael Lum, D.D.S.*, California originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that *Michael Lum, D.D.S.*, California's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review, *Michael Lum, D.D.S.*, California's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative: _____

Printed Name of Individual or Legal Representative Witness: _____

Date: _____

FOR OFFICE USE ONLY We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please specify)