

JAMES F. LESCH, D.D.S.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES & CONSENT FOR USE AND  
DISCLOSURE OF HEALTH INFORMATION**

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PATIENT

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

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**TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out our treatment, payment activities and healthcare operations.

**Notice of Privacy Practice:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice of Privacy Practices accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. These changes may apply to any of your protected health information that we maintain.

You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

**James Lesch**

**Telephone: 952-469-5213**

**20785 Holyoke Ave. W., P.O. Box 310  
Lakeville, Minnesota 55044-0310**

**Consent Does Not Expire after One Year.** By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the release of health records to an accident and health insurer, health service plan corporation, health maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

**SIGNATURE**

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative Name: \_\_\_\_\_

NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**