Michael B. Lee, D.D.S.
Diplomate American Board of Oral & Maxillofacial Surgery

7523 State Road Cincinnati, Ohio 45255
513-232-8989 www.cincinnatijawsurgery.com

Acknowledgement of Receipt of Notice of Privacy Practice Dr. Michael B. Lee D.D.S.

I, _____(print name) have been offered a copy of the Notice of Privacy Practices for Dr. Michael B. Lee DDS, Inc. detailing how my health information may be used and disclosed under federal and state laws.

Patient/Legal Representative Signature _____
Date: _____

Release of HealthCare Information

May we discuss your healthcare with someone other than yourself? Yes/No
If yes, whom may we discuss it with: _____?
(If you are 18 years or older and would like a parent/guardian/spouse to obtain information please complete.)
Relationship to patient: Spouse/ Parent/ Grandparent /Daughter /Son/Friend/Other:
_____

Phone Message Consent:

For the purpose of confirming appointments, lab results and surgery scheduling we may need to contact you. When you are not available for us to speak with directly please indicate below your preference for phone messages:

1. My cell phone voice mail #: _____
2. My home phone answering machine#: _____
3. My work phone # _____

I DO NOT CONSENT TO MESSAGES:
I _____, wish to be contacted personally and I do not authorize detailed messages regarding my medical care to be left on an answering machine, voicemail, or with others.

Signature: _____ Date: _____