MICHAEL LUM, D.D.S., INC
426 E. CALAVERAS BLVD
MILPITAS, CA 95035
Phone: (408)262-1710
Fax: (408)262-1864
Email: Office@Lumdds.com
www.lumdds.com

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)