COLONIAL DENTAL GROUP
4940 LINGLESTOWN ROAD
HARRISBURG, PA 17112
717-901-7045

Notice of Privacy Policies
Patient Acknowledgement

Patient Name: ____

Date of Birth: ____

I have read this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and discloses of my protected health insurance information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: ____

Date: ____

Relationship to patient (if signed by a personal representative of patient):

____

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