BOBBY WANG, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES AND CONSENT FOR DISCLOSURE FOR

TREATMENT, PAYMENT AND OPERATIONS

ACKNOWLEDGEMENT AND CONSENT

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control of this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office as described in the Notice.

Signature of the Patient or Representative

Print Name of Patient or Personal Representative

DATE