Sharon K. Hosea, D.D.S
Nathan C. Stachel, D.D.S.
635 W. 14 Mile Rd.
Clawson, MI 48017
248.288.6070

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosure of my protected health information that may be made by the practice, my individual rights, how I may exercise these rights and the practice's legal duties to my information.

I understand that this practice reserves the right to change terms of the Notice of Privacy Practices, and to make changes regarding all protected health information either residing at or controlled by the practice. If changes to this policy occur, this practice will provide me a revised Notice of Privacy Practice upon request.

Signature: _____

Date: _____

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