ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Lee and Melazzo D.M.D.,P.C. Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Name (Type or Print) Date

_____

Signature

By signing below I am giving Lee and Melazzo, D.M.D., P.C. permission to discuss my treatment, appointments and financial issues with the following people:

_____

_____

_____

_____

Signature and date