ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

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Please print your name here

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Signature

____

Date

I allow any records and/or information to be disclosed or released to:

_____Another dental professional

_____Another medical professional

_____Other (family, friends, guardian, step-parents, grandparent, babysitters…)

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FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_____The Patient refused to sign.

_____Due to an emergency situation it was not possible to obtain an acknowledgement.

_____We weren't able to communicate with the patient.

_____Other (Please provide specific details)

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