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.

Please Print Patient Name

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…)

_____

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.

_____

_____