ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices. (Agreement to protect personal health information).

_____

Patient Name (Please Print)

_____ _____

Patient Signature Date

OR

_____ _____

Signature of Personal Representative Date

Authority of Personal Representative to Sign for Patient (check one):

___Parent ___Guardian __Power of Attorney __Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___An emergency prevented us from obtaining signature.

___A communication barrier prevented us from obtaining signature.

___The individual was unwilling to sign.

___Other: _____

_____ _____

Staff Member Signature Date