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ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THIS DENTAL PRACTICE'S HIPPA NOTICE OF PRIVACY PRACTICES.

____
PATIENT NAME(PLEASE PRINT)

______________________________ ______________________________
PATIENT SIGNATURE *DATE*

OR

____
SGNATURE OF PERSONAL REPRESENTATIVE

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 BOVE OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES, BUT IT COULD NOT BE OBTAINED BECAUSE:

_____ AN EMERGENCY PREVENTED US FROM OBTAINING ACKNOWLEDEGEMENT.

_____ A COMMUNICATION BARRIER PREVENTED US FROM OBTAINING ACKNOWLEDGEMENT.

_____ THE INDIVIDUAL WAS UNWILLING TO SIGN.

_____ OTHER

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______________________________ ______________________________
STAFF MEMBER SIGNATURE *DATE*