THIS COMPLETED FORM REMAINS IN THE PERMANENT RECORD OF THE PATIENT

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

PATIENT MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

_____
PRINTED NAME OF PATIENT

I, the undersigned Patient, have received a copy of the Notice of Privacy Practices of this dental practice. I also hereby authorize the dental practice named above to discuss my dental treatment information and dental financial information (which includes all information classified as Protected Health Information or PHI under the federal law HIPAA) at said dental practice with the following persons who shall be active in my dental care. I understand that to revoke this authorization, I must notify the dental practice named above in writing. **Please place "N/A" or just leave the Recipient lines blank if not applicable but please sign and date regardless.**

_____ _____
Name of Authorized Recipient Relationship of Authorized Recipient

_____ _____
Name of Authorized Recipient Relationship of Authorized Recipient

_____ _____
Signature of Authorized Patient Date Signed by Patient

FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE

We attempted to obtain written acknowledgement of recipient of our Notice of Privacy Practices from _____(Printed Name of Patient) but acknowledgement could not be obtained because (Please Check One):

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify): _____
  _____

_____
(Signature and Printed Name of Office Agent) and (Title of Office Agent)

_____
(Date Signed by Office Agent)