Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please list below anyone with whom you give your consent for us to disclose or discuss your treatment, healthcare or financial information. This information is private and without your consent will not be disclosed to any individual. *(With the exception of your referring dentist and your insurance company).*

______________________________ ______________________________
Name……………………………………..Relationship Name……………………………………..Relationship

______________________________ ______________________________
Name……………………………………..Relationship Name……………………………………..Relationship

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