# NOTICE OF PRIVACY PRACTICES

**As a medical office, we are required by applicable federal and state law to maintain the privacy of your health information. We are required to provide you with this notice regarding our privacy practices, our legal duties, and your rights concerning your information.**

**If you would like to review our "Notice of Privacy Practices" information sheet, please see the receptionist.**

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

I/we _____, have had the opportunity to review,
(Print patient name, and the name(s) of any children – under 18 – also to be seen in our office)
or have received a copy of the "Notice of Privacy Practice".

I also give permission to discuss my dental card, appointments, and account information, to the following people: (i.e. spouses, parent, step-parents):

| PRINT NAME | RELATIONSHIP | DATE |
|---|---|---|
| _____ | _____ | _____/_____/_____ |
| _____ | _____ | _____/_____/_____ |
| _____ | _____ | _____/_____/_____ |

_____ _____/_____/_____
**Patient/Parent Signature** **Date**

*You may refuse to sign this acknowledgement

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## OFFICE USE ONLY

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

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency prevented us from obtaining the acknowledgement
- □ Other (please specify) _____