Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign this Acknowledgement

EMAIL ADDRESS:____

I, (print name) ____, have received a copy of this office's Notice of Privacy Practices.

Under the requirements of HIPAA, we are not allowed to give medical/dental information to anyone without the patient's consent. If you wish to have any of your medical/dental information released to family members or friends, please list the individual(s) below:

Name____________________________________ Phone_______________________
Relationship____________

Name____________________________________ Phone_______________________
Relationship____________

You are not required to sign to receive care in our dental office.

How would you like us to communicate with you? Our dental office sends appointment reminders, information about treatment, insurance information, and other communications.

For Phone, Text and Email Communications:

By signing below, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

My preferred method of contact is (check all that apply):

Contact me by phone at: Home (__________)___________________________

Cell (__________)___________________________

Work (__________)___________________________

Text Me Email Me Do Not Contact

Signature:____ Date: ______________________

Please contact our office right away if you get a new telephone number.

Office use only:

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

Individual refused to sign
An emergency situation prevented us from obtaining acknowledgement
Communication barriers prohibited obtaining the acknowledgement

Consent Revoked. Date/Initials: ________/________