ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your health information may be used in our office to conduct scheduling and coordination of care between the doctor, dental assistant, hygienist, business staff and other health care providers. We may include your health information (including x-rays) with communications related to your treatment and we may do this with insurance forms filed via mail or electronically. We may communicate with you via phone, messages, postcards/letters, or electronically.

I, _____, have read and understand this office's Notice of Privacy Practices.
Print Name

Signature: _____ **Date:** _____

NOTICE: If there are any individuals that we are authorized to share your health information with please list below and their affiliation to you.

Name: _____ Affiliation: _____

Name: _____ Affiliation: _____

Name: _____ Affiliation: _____

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

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____