ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****This form will be retained in your dental records.****

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to offer this Acknowledgement that you received our **Notice of Patient Privacy Practices**.

We keep a record of the dental care services we provide you. You may ask to have access to that record and have that record copied for you. You may also ask to have that record corrected. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our <u>Notice of Patient Privacy Practices</u> describes in more detail how your health information may be used and disclosed, and how you can access your information.

I acknowledge that I have <u>received</u> a copy of this office's Notice of Privacy Practices. My signature does <u>not</u> bind me to any contract or contractual relationship, and it does <u>not</u> mean that I agree with the contents of your Notice. **My signature only signifies that I have <u>received</u> your Notice.**

____
{Please Print Patient's Name}

____
{Patient's Signature}

____
Relationship to Patient if patient is a minor
(such as parent, guardian, etc)

____
{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 this acknowledgement on this date:_______ staff's initals:______
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)____