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ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):
☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____
_____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgement.
__ The individual was unwilling to sign.

_____ _____
Staff Member Signature Date