HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____

{Signature of Patient and/or Guardian} {Date}_____

{Relationship to Patient} ☐ or Other: _____

I, _____, acknowledge and allow (Name of Practice/Dentist) to share my information with the following people besides those already stated within the Notice of Privacy Practices.

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse _____

☐ Child(ren) _____

☐ Other _____

☐ No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) _____ between (time) _____

Please call ☐ my home phone ☐ my work number ☐ my cell number

_____ _____ _____

If unable to reach me:

☐ you may leave a detailed message ☐ please leave me a message asking for a return call OR

☐ you may e-mail me at _____

Signed: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____