CANTRELL FAMILY DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Notice to Patient and/or Personal Representative:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information or your children's health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

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

Patient's Name (Please Print) _____ _

Patient's Signature_____ Date _____

AND/OR

Child Patient's Name (Please Print) _____

Child Patient's Name (Please Print) _____

Child Patient's Name (Please Print) _____

Child Patient's Name (Please Print) _____

Signature of Personal Representative _____ Date _____

Authority of Personal Representative to Sign for Patient (check one)

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other _____

This form does not constitute legal advice and covers only federal, not state law.

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.
___ Other:

_____ _____

Staff Member Signature Date

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