



ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY POLICIES
PATIENT'S CONFIDENTIALITY INSTRUCTIONS

Last Name: First Name: MI: Birthdate:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices made available to me in the patient waiting area. I understand that I am giving my permission to use and disclose my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

It is important for us to honor your confidentiality. Please check your preferences below.

- You may discuss my dental/account information only with me.
I give my permission to discuss my dental/account information with the following people:

Name: Phone: Relationship:
Name: Phone: Relationship:
Name: Phone: Relationship:
Name: Phone: Relationship:

Yes or No You may leave me a message with details on my voicemail at:

Home #: Cell #: Work #:

Patient (or Parent/Guardian) Signature: Date:

Print Name:

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices. However, acknowledgment could not be obtained because:

- Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other: