Dental Offices, LLP

Acknowledgement of Receipt of Notice of Privacy Practices

By signing below, I hereby acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by the office and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health information for treatment purposes, payment activities and healthcare operations of the office.

** You may refuse to sign this acknowledgment**

I have received a copy of Dental Offices, LLP's Notice of Privacy Practices:

✓ Print patient name:_____

✓ I give the Practice permission to share medical information with the following relatives or friends who may be involved in my care:_____

_____

✓ Patient signature:_____
(or signature and relationship of Personal Representative)

✓ 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Staff initials
_____

_____

_____

Revised 08/05/2015