Falls Family Dental

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient: 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. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement of receipt but we must keep a record of your refusal. If you refuse to sign this acknowledgement of receipt, we are required to treat you and we may still use and/or disclose your health information as HIPAA permits.

I acknowledge that I have received a copy of this office's Notice of Privacy practices.

_____

Print patient name

_____

Signature patient name or Legal Representative

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement or receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- The patient refused to sign
- Due to an emergency situation it was not possible to obtain acknowledgement
- We were unable to communicate with the patient
- Other (provide specific details)

  _____
  _____
  _____

_____ _____

Employee signature Date

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