

fort mill pediatric dentistry

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name _____
Address _____

I have received a copy of this office's Notice of Privacy Practices.

I have read and understand this form. I authorize the disclosure of my child's health information as described in this form.

Date _____ Signature _____
Relationship to patient _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of authority to sign this form.

Relationship to Patient _____
Print Name _____
Source of Authority _____

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (please specify) _____

Prepared by _____

Signature _____

Date _____