



CITY FAMILY DENTAL & IMPLANT CENTRE

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICE

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

Print Name: _____ . Date: _____ .

Patient Signature: _____ .

OR

Signature of Personal Representative: _____ .

Print Name: _____ . Date: _____ .

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

Parent Guardian Power of Attorney Other: _____ .

Please. Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

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 (Check which apply):

- 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: _____ .