

ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of Family & Implant
Dentistry's Notice of Privacy Practices.

I give permission for the office to speak to the following people on my behalf:

- Access to account information: Insurance, claims, claims processing
- Access to clinical information: Treatment, diagnosis, clinical notes

I can reverse these permissions at any time by notifying the office.

Print Name

Signature

Date

*****FOR OFFICE USE ONLY*****

We attempted to obtain written acknowledgement of receipt for Notice of Privacy Practices, but could not be obtained because:

- ___ Individual refused to sign
 - ___ Communication barriers prohibited obtaining the signature
 - ___ An Emergency situation prevented us from obtaining the signature
 - ___ Other (Please Specify)
-