

Acknowledgement of Receipt of Notice of Privacy Practices

Date: _____

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I _____ have received a copy of Delaware Maryland Dental's Notice of Privacy Practices, which describes how my health information is used and shared. I understand that Delaware Maryland Dental has the right to change this notice at any time. I may obtain a current copy by contacting the Facility Privacy Official.

Print Patients Name: _____ Signature: _____

For Minor Children:

Parents Name: _____ Signature: _____

We do call to remind you of appointments; Do you wish a reminder call? _____

if yes please list:

Phone number _____ May we leave a message on this number? _____

If you wish our office to share information (appointment times, history, treatment plans, etc) with a spouse, parent, or anyone else please see our front desk as we need written permission prior to being able to share this information.

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 prohibit obtaining the acknowledgement

___ Other(Please Specify) _____

