Acknowledgment of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that our Notice of Privacy Practices is available for your review or to document our good faith effort to have a copy of our Privacy Practices available to you.

** You may refuse to sign this acknowledgement**

I,_____, understand a copy of this office's Notice of Privacy Practices is available upon request.

Patient Name (Printed)

Signature

Date

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I,covered under the Privacy Practice regarding myself.	, authorize the following person(s) to have access to information
Name (Printed)	Relationship
Name (Printed)	Relationship
Name (Printed)	Relationship

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

- $\hfill\square$ Communications barriers prohibited obtaining the acknowledgement
- $\hfill\square$ An emergency situation prevented us from obtaining acknowledgement
- □ Other (*PleaseSpecify*)

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