

Dunn Orthodontics

Your Privacy Is Important to Us

Acknowledgment of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of Dunn Orthodontics. I hereby authorize as indicated by my signature below, Dunn Orthodontics to use and to disclose my Protected Health Information for any necessary clinical, financial and insurance purpose, as authorized in the Patient Consent form.

Print Patient Name

Address

Print Parent/Guardian Name (If a minor)

City/State/Zip

Signature

Date

Please check your preferred means of communication:

You may contact me at my home telephone number _____

You may contact me on my mobile telephone number _____

You may contact me on my work telephone number _____

You may send me an email at: _____

Other _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

Date Added/Removed: _____

Date Added/Removed: _____

Date Added/Removed: _____

Date Added/Removed: _____

* * *

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) _____

Staff Person Initials _____