Hope DENTAL PROFESSIONALS

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies
(Adult)

I have received a copy of the Notice of Privacy Practices of Hope Dental Professionals. I hereby authorize, as indicated by my signature below, 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 Name_____ Address_____

Signature_____ Date_____

Please check your preferred means of communication:

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:.

2._____Date Added / Removed: _____

3_____ Date Added / Removed: _____

4. _____ Date Added / Removed:_____

5. _____ 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)_____