CONTOS SMILE CENTER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.

- I have received a copy of this office's Notice of Privacy Practices.
- I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement;
- This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Please Print Name: _____

Signature: _____ Date: _____/_____/_____

If you are signing as a personal representative of the patient, describe your relationship to the patient (minors under 18.)

Relationship to patient: _____ Print name: _____

Authorization for Release of Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____, (patient name) authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself in the following manner. (Spouse, Children, Other)

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

HIPAA Officer:_____ Date: _____