
ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES and AUTHORIZATION TO RELEASE

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge I have received a copy of Abundant Dental Care's HIPAA Notice of Privacy Practices:
NOTE: YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

I, the undersigned, have received a copy of Abundant Dental Care's Notice of Privacy Practices.

Patient's Printed Name_____
Date_____
Signature

Authorization to Release Information (Optional)

I, the undersigned, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

Printed Name_____
Phone Number_____
Printed Name_____
Phone Number

Dental Office Use Only

(To be completed if patient chooses not to sign above)

We attempted to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgement
- A communication barrier prevented us from obtaining acknowledgement
- The individual declined to sign
- Other: _____

Signature of Witness_____
Date