OralDynamics
Advanced Dental Esthetics

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have read a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____ **Date:** _____

In order to comply with specific rules regarding the Health Insurance Portability & Accountability Act (HIPAA), it is our office policy not to release confidential information by home telephone, answering machine, work telephone, voice mail, or cell phone. Information will not be left with any unauthorized person who may answer the phone.

Please complete the following form authorizing the staff at Oral Dynamics to leave information pertaining to your care or to confirm an appointment by the following methods:

Home phone/answering machine	_____	yes	_____	no	_____ n/a
Work phone/voice mail	_____	yes	_____	no	_____ n/a
Cell phone/voice mail	_____	yes	_____	no	_____ n/a
E-mail address	_____	yes	_____	no	_____ n/a

Please list the name(s) of any individual you are authorizing us to leave information with concerning your care or an appointment: _____

_____

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)

_____

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