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Orthodontic Specialist – Children and Adults

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my/my child's health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

Patient Name:_____

Name of Parent or Guardian:_____

Relationship to Patient: _____

Signature: _____ Date:_____

FOR OFFICE USE ONLY

We attempted to obtain the parent/patient signature in acknowledgement of this 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)

_____

_____

_____

Date:_____ Initials:_____