Family Dental Group

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I,_____, have viewed the posted Notice of Privacy Practices for Family
(Please Print Name)
Dental Group and have been advised of my rights to have a written copy if I wish to have one.

I request a written copy of the Notice of Privacy Practices

I do not wish to have a written copy of the Notice of Privacy Practices.

I give my permission for Family Dental Group to discuss and/or release dental and/or account information to the following people. I can revoke this permission at any time with prior written notice to Family Dental Group.

1. _____
2. _____
3. _____

_____
(Signature) (if minor - parent or guardian)

_____
(Date)

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)