HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Dentofacial Associates, P.A.

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I ______________________ (Patient's Name) understand that as part of my health care, Dentofacial Associates, P.A. 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 acknowledge that I have been provided with an understanding that Dentofacial Associates, P.A. **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

☑ I have the right to review Dentofacial Associates, P.A. **Notice of Privacy Practices** prior to signing this acknowledgement.

☑ that Dentofacial Associates, P.A. reserves the right to change their **Notice of Privacy Practices** and prior to implementation of this will mail a copy of any revised noticed to the address I've provided if requested.

Signature of Individual or Legal Representative Witness X______________________

Printed Name of Individual Name or Legal Representative Witness X______________

Date: _____/______/_______

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Others (please specify)

____

____

____

Dentofacial Associates, P.A.
Privacy Officer

____

Date