



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received (or have been offered) a copy of Annapolis Family Dentistry's Notice of Privacy Practices. By signing this form, I am giving the office my consent to use and disclose health information about me for treatment, payment, and health care operation purposes.

Signature: _____

Patient Name: _____

Date: _____

Dependent Family Members also covered by this acknowledgement:

I authorize the following people to have access to my dental records:

Parent/Guardian: _____

Spouse/Partner: _____

Relative: _____

Other: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following reason:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgments
- An emergency situation prevented us from obtaining acknowledgements
- Other (please specify):