ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy by your request of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge the Notice of Privacy. You may refuse to sign this acknowledgement, if you wish.

I acknowledge this office's Notice of Privacy Practices.

_____
Please print your name here

_____
Signature

_____
Date

I authorize Dr. Orr and Staff to review and discuss my dental information and treatment with (list person(s) below or write Not Applicable).

_____ Relationship _____

X_____
Signature

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____ _____

Employee signature *Date*