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(360) 695-1515 – Fax: (360) 694-8449

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I_____, have received a copy of this office's Notice of Privacy Practices. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to me during the period of such Dental care, to third party payers and/or health practitioners.

_____
(Please Print Name)

_____
(Signature)

_____
(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:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify)

Date:

_____

_____