

Acknowledgement of Receipt of Notice of Privacy Practices

I received a copy of the Notice of Privacy Practices of **Hutchens Family Dentistry**, or a copy has been made available to me. I hereby authorize as indicated by my signature below, **Hutchens Family Dentistry** to use, and disclose my protected health information for any necessary clinical, financial, and insurance purpose as authorized.

Print Name

Address

Signature

Date

Please check your preferred means of communication (you may check more than one):

- You may contact me at my home telephone number
- You may contact, text me on my mobile telephone number
- You may contact me on my work telephone number
- You may send an email _____
- Other: _____

Please list ALL authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

_____ Relationship _____ Date _____ added/removed

_____ Relationship _____ Date _____ added/removed

_____ Relationship _____ Date _____ added/removed

_____ Relationship _____ Date _____ added/removed

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify): _____ Staff Person

Initials: _____