HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, _____, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

_____

{Signature of Patient and/or Guardian} {Date}_____

{Relationship to Patient} Self or Other: _____

I, _____, acknowledge and allow Mossmann Family Dental to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information (including but not limited to: diagnosis, treatment, appointment dates and times, etc) to:

[ ] Spouse _____

[ ] Child (ren) _____

[ ] Other _____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Please indicate your contact preference:

Please call: [ ] my home phone [ ] my work number [ ] my cell number

May we: **Text** [ ] yes [ ] no **Email** [ ] yes [ ] no

If unable to reach me:

[ ] you may leave a detailed message at the above preference

[ ] please leave a message asking for a returned call

I understand that communication via unsecured modes of transmission can be subject to a breach in my information.

Signed: _____ Date: ____/____/_____