

# ACKNOWLEDGEMENT OF RECEIPT

## NOTICE OF PRIVACY PRACTICES (HIPAA)

I, \_\_\_\_\_, acknowledge that I have been provided the opportunity to review the **Notice of Privacy Practices** for **Riverside Dental Arts, PLLC**, which is available in the waiting room and upon request.

I understand how my protected health information may be used and disclosed, and I acknowledge receipt of this Notice.

**Please check one:**

Patient       Parent       Legal Guardian

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## AUTHORIZATION TO RELEASE INFORMATION

**Purpose:** This authorization permits Riverside Dental Arts, PLLC to disclose protected health information, as allowed under the Notice of Privacy Practices, to the individual(s) listed below.

I, \_\_\_\_\_, authorize the following person(s) to receive information regarding my dental care:

<b>Print Name</b>	<b>Relationship</b>
_____	_____
_____	_____
_____	_____
_____	_____

This authorization will remain in effect unless revoked by me in writing.

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## OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices; however, acknowledgment could not be obtained because:

- Individual refused to sign
  - Communication barriers prevented obtaining acknowledgment
  - Emergency situation prevented obtaining acknowledgment
  - Other (specify): \_\_\_\_\_
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**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_