Amber Dental Care

Amani Alkhairi, DMD, PA
1009 Amber Rd. Orlando, FL 32807

HIPPA Notice of Privacy Practices ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice and Privacy Practices.**

Patient Name _____ on _____
(Please Print) (Date)

_____
Patient Signature / Or Signature of Personal Representative
Sign for Patient (check one): ___ Parent ___Guardian ___Power of Attorney ___ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement. You also are entitled to a copy of this consent after you sign it.

Revocation of Consent *(REFUSAL)*
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice or revocation. I understand that you may decline to treat or continue to treat me after I have revoked my consent.

_____ _____ _____
Patient Signature / Or Signature of Personal Representative Date

_____ _____

Dental Office Use Only
I tried to obtain written Acknowledgement by the individual noted above of our HIPPA policy, but it could not be obtained because:
o An emergency prevented us from obtaining acknowledgement.
o A communication barrier prevented us from obtaining acknowledgement.
o The individual was unwilling to sign.
o Other: _____
Office Staff Signature_____Date_____