

PDA Dental Group

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you a copy of our HIPAA Notice of Privacy Practices (Notice), which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have been offered and/or received a copy of this organization's HIPAA Notice of Privacy Practices.

Please print patient name here

Signature of patient or guardian and printed relationship if not patient

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation, it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other *(Please provide specific details)*

Employee signature

Date