ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices of NorthPark Dental Group. By signing below I authorize NorthPark Dental Group to use and disclose my protected health information consistent with what is in the Notice of Privacy Practices.

You May Refuse to Sign This Acknowledgement

_____

Print Name **Date of Birth**

_____

Signature **Date**

PLEASE CHECK YOUR PREFERRED MEANS OF COMMUNICATION

- ☐ Home # _____
- ☐ Mobile # _____
- ☐ Text _____
- ☐ Work # _____
- ☐ Email _____

PLEASE LIST AUTHORIZED PERSONS WITH WHOM WE MAY DISCUSS YOUR PROTECTED HEALTH INFORMATION (PHI) IN ADDITION TO CUSTODIAL PARENTS AND LEGAL GUARDIANS

1. _____Date Added/Removed: _____
2. _____Date Added/Removed: _____
3. _____Date Added/Removed: _____
4. _____Date Added/Removed: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice or 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 (specify) _____

Staff Personnel Initials _____