ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR ORTMAN FAMILY DENTISTRY

****You May Refuse to Sign This Acknowledgement****

I, ____________________, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name} ______________________________

{Signature} ______________________________

{Date} ______________________________

{Parent or Guardian Signature if minor}: ______________________________

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, ______________________________, Date of Birth ______________, request that the following be followed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis (es), test results, date of services.

- Sensitive Protected Health Information (HIV- related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship

NAME	PHONE NUMBER	RELATIONSHIP

- You may leave Protected Health Information on my answering machine/voicemail: Phone Number ______________________
- You may leave me a text message: Text Phone Number __________________
- You may email me (unencrypted) for dental appointments:
  Email Address: ______________________________
- You may fax me for dental information: Fax Number ____________________
- Other ______________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of 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 acknowledgement
  Other (Please specify)