ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I certify that I have received/been offered a copy of this office's Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of Ben B. Ross, DMD, at Pantops Prosthodontics, LLC.

_____

Please Print Name of Patient or Personal Representative

_____

Signature of Patient or Personal Representative Description of Personal Representative's Authority

_____

Date

I authorize you to release my personal health information to the following individual(s) (Please print). You may list as many individuals as you wish.

_____ _____

_____ _____

_____ _____

I understand I may change this list at any time.

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

☐ Communications barriers prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify)

_____