

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, acknowledge that I have received a copy of Dona W Prince DDS PC Notice of Privacy Practices.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal Representative, etc.)

I authorize and agree that Dona W Prince DDS PC may disclose my protected health information to the following persons, each of who is directly involved in my care:

1. _____ 2. _____
3. _____ 4. _____

I acknowledge and agree that Dona W Prince DDS PC may disclose my protected health information to the persons set forth in this form unless and until I object to such disclosures, which must be provided in writing to Dona W Prince DDS PC.

Patient or legally authorized individual signature

Date

Printed Name if signed on behalf of the patient

Relationship (parent, legal guardian, personal Representative, etc.)

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 (please specify):

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____