toothtales™

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (954) 236 5273.

Patient's name (please print) Date

Signature (if minor Parent or Guardian)

Patient's Legal Representative

Signature of Legal Representative Date

FOR DENTAL 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)