BIRCH TREE
DENTISTRY
DR. BOUZ DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Please print patient name here *Date*

_____

Signature

Under HIPAA, we may share limited information with family members or others involved in your care or payment unless you object. Please list any individuals with whom you authorize our office to discuss your protected health information. This section helps us document your communication preferences regarding family members and others involved in your care. You may update these preferences at any time by notifying our office.

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

Information Authorized for Disclosure (Check all that apply):

☐ Appointment scheduling ☐ Treatment information ☐ Billing and financial information
☐ Insurance and payment details ☐ All information related to my care ☐ Other (please specify):

_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_____ Check here if signature was not possible to obtain.

Please indicate reason signature was unable to be obtained: _____

Employee signature *Date*