



PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You have the right to refuse to sign this Acknowledgement

I, _____, have (Signature of Patient)

received a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

Print Patient's Name

Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES. We were unable to obtain acknowledgement for the following reason:

- Patient refused to sign
Other (Possible reasons: Language difficulty, communication barriers, dental emergency)

(Printed Name)

(Signature of employee attempting to gain acknowledgement)

