CARRIAGE FAMILY DENTAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You Have the Right to Refuse to Sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.
Name

_____
Responsible Party, Print Name

_____ _____
Signature Relationship to Patient

_____
Date

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the privacy act to people other than yourself. Allows us to discuss treatment, appointments or finances with parents, spouses, secretaries, etc. as you designate.

I, _____, authorize the following person(s) to have access to information
Name covered under the Privacy Practice regarding myself.

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

_____ _____
Print Name Relationship

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 the acknowledgement
☐ Other *(Please explain):* _____

_____