RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse to Sign This Acknowledgement"

I, ______________________________, have received a copy of this practice's Notice of Patient Privacy Practices and hereby give my consent to your use and disclosure of my protected health information to provide treatment, payment and health care operations.

☐ I give permission for BAY COLONY DENTISTRY staff to contact the following individual(s) to discuss treatment and payment options:

____

(Name) (Relationship to Patient) (Phone/Cell)

____

(Patient Name)

____

(Patient/Parent Signature) (Date)

Practice Purposes Only

Our practice attempted to obtain written statement for Notice of Privacy Practices. Receipt could not be obtained for the following reason:

☐ Patient Refused to Sign Notice

☐ An emergency occurred and prevented us from obtaining

☐ Other (Please Specify)

____

____

(Staff Signature)