HI 5 ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: ___________________________________

I ___________________________, have received a copy of this office's Notice of Privacy Practices.
(Print Responsible Party Name)

____
(Responsible Party Signature) (Date)

May we leave a detailed voice mail message?____Yes ____No If so, what number? ____Home____ Cell ____ Both

*Please note, it is your responsibility to notify our office of phone number changes or if you wish to revoke this authorizations for detailed messages to be left.

May we send you automated appointment reminders via text and email and phone call? ____ Yes ___ No

Please list individuals with whom we may share PHI (Personal Health Information) of the above named patient with:

Name: _________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

** Your signature gives us permission to share PHI (Personal Health Information) with the above-named individual(s) for the period of the date of this form through the end of your active treatment***

For Official 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)

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