BLUE SKY SMILES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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

(Please Print Name)

_____ _____

Signature Date

If this consent is signed by a personal representative on behalf of the patient please complete the following:

Guardian/ Parent: _____ Relationship to Patient: _____

Please list the names of anyone (i.e. spouse/ child/ parent) whom you would like us to release any information regarding your dental/ medical records information. Medical Doctors, Pharmacies, and Insurance Companies excluded.

Name:_____ Name:_____

Name:_____ Name:_____

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 acknowledgement
- ☐ Other (Please Specify)

_____