

ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE HIPAA

You **may** refuse to sign this acknowledgement.

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

_____ Date _____
Please **print** your name above

Please **sign** your name above

I may choose to add someone to access my account information such as: appointments, billing questions/payments, proposed treatment/procedures done, insurance, and/or prescriptions, etc. I may also **remove/change** this person at any time by **updating this page in office.**

You may share my information with: _____

[] I refuse to sign this acknowledgement.

FOR OFFICE USE ONLY

Sullivant Dentistry attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, HOWEVER, acknowledgement could NOT be obtained because:

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.