



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

SECTION A: The Patient:

Name: _____ Birthdate: _____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, _____, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: _____ Date: _____

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

I, _____, give permission to Coulee Family Dental to discuss my dental treatment and account information with the following people:

Name:	Relationship:
_____	_____
_____	_____

Comments: _____

This authorization shall be effective for past, present, and future periods, unless I revoke it. (NOTE: You may revoke this authorization at any time by notifying Coulee Family Dental, preferably in writing.)

Signature of the Individual Giving this Authorization

Date

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

Describe the reason why the individual would not sign this form:

Signature: _____ Date: _____

Print Name: _____ Title: Office Manager

Include this acknowledgement of receipt in the individual's records.