ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:____________________________ **Date of Birth:**_____________________

HIPAA AUTHORIZATION
I hereby acknowledge that I have received and reviewed a copy of Bisson Dental's Notice of Privacy Practices explaining:

- How Bisson Dental will use and disclose my protected health information
- My privacy rights in regard to my protected health information
- Bisson Dental's obligations concerning the use and disclosure of my protected health information

I understand that Bisson Dental has the right to change its Notice of Privacy Practices and that I may contact Bisson Dental at any time to obtain a current copy of the Notice of Privacy Practices.

I hereby give authorization to the following individuals to access my personal health information:

Name:_____________________________ Name:________________________________

Relationship:_______________________ Relationship: __________________________

Phone Number: ____________________ Phone Number:________________________

You may refuse to sign this acknowledgement.

____________________________________ ____________________________________
Patient / Parent / Legal Guardian Signature Date

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
_______An emergency situation prevented us from obtaining a signature
_______Communications barriers prevented us from obtaining a signature
_______Other (please specify)____

____________________________________ ____________________________________
Staff Member Date