# 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
Patient's Name

of Privacy Practices.*

_____
Printed Name of Patient or Guardian

_____
Signature of Patient or Guardian

_____
Date

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

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

*Available upon request.

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**AUTHORIZATION TO RELEASE INFORMATION***

***Required** for patients 18 years or older who are not the responsible party on their account.

Patient Name: _____

I hereby authorize Dr. Simmons to release any and all information regarding my dental care to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ Date: _____
Signature of Patient