ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

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

____

Please print your name here

____

Signature

____

Date

MARR & THOMPSON
DENTAL GROUP
5108 N. Clinton
Fort Wayne, IN 46825

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

____

____

____

____________________________ ______________

Employee signature *Date*

NAME OF OFFICE: MARR & THOMPSON DENTAL GROUP
5108 N. Clinton
Fort Wayne, IN 46825

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, ______________________________, Date of Birth: __________, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), tests results, dates of service.

PLEASE CHECK ALL THAT APPLY

☐ **You may disclose information to my family members and or non-family members. Please list name, phone number, and relationship.**

Name	Phone Number	Relationship

☐ **You may leave Protected Health Information on my answering machine/voicemail.**

Phone Number: ______________________________

☐ **Other:** ______________________________

You may disclose insurance information to a referring dental office.

Patient's Signature: ______________________ **Date:** __________

______________________ ______________________
Patient's Printed Name **Social Security Number**

______________________ ______________________
Patient's Signature (or Guardian, if minor) **Date**

______________________ ______________________
Witness (optional) **Date**