East Center Dental
Family, Cosmetic & Implant Dentistry

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, have read a copy of this Office's Notice of Privacy Practices.

PLEASE PRINT NAME_____

Do you have anyone that you would allow our office to release dental information to? Yes____No____

Please List:

Name:_____Date of Birth:_____

Name:_____Date of Birth:_____

If your child (under age 18) is brought to our office for his/her dental appointment by someone other than yourself, may we release dental/medical information to him/her? Yes_____No _____

SIGNATURE:_____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)_____