

---

**Bridgepointe Family Dentistry  
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 of Privacy Practices.

\_\_\_\_\_  
{Please Print Name}

\_\_\_\_\_  
{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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
  
© 2002 American Dental Association  
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

# NOTICE OF PRIVACY PRACTICES AND DISCLOSURE ALLOWANCES

## Acknowledgement of Receipt

Date: \_\_\_\_\_

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Patient Signature

If completed by a patient's personal representative or parent, please print and sign your name in the space below.

\_\_\_\_\_  
Personal Representative Name (Please Print)

\_\_\_\_\_  
Personal Representative's Signature

\_\_\_\_\_  
Relationship

I authorize the disclosure of my health and financial information to the following family members or personal representatives:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Patient or Representative's Name (Please Print)

\_\_\_\_\_  
Patient or Representative's Signature

