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)

_____

_____

_____

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