



Edgewater Dental

ACKNOWLEDGEMENT OF RECEIPT FOR THE 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 Edgewater Dental's Notice of Privacy Practices.

Print Name _____

Signature _____

Date _____

For our patients who are 18-26 still insured by parents, or are adults that have parents/children or guardians involved in their financial and dental care: Please initial your decision.

_____ I give my parents/guardian/children permission to be involved in my dental care – financially, to make appointments and to have my dental treatment discussed with them.

Names of parents/children/guardian _____

_____ I decline having my parents/children/guardian involved in my dental care – financially, to make appointments and to have my dental treatment discussed with them.

I will allow any records and/or information to be disclosed and released to:

_____ Another dental professional

_____ Another medical professional

FOR OFFICE USE ONLY

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

_____ Patient refused to sign

_____ Due to emergency situation, it was not possible to obtain an acknowledgement.

_____ We were not able to communicate with the patient.

_____ Other(Provide specific details)