



Edgewater Dental

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 this 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 of Patient _____

Signature _____ Date _____

If you are over 18 and have someone who assists you with your financial and dental care, please initial your decision of who can be involved with your care. You can decline to have someone involved as well.

_____ **I give permission** for my parents/legal guardian/children/personal friend to be involved in my dental care- financially, to make appointments and to discuss my dental treatment with them. I may change this at any time.

Names of parents/children/guardians _____

_____ **I decline permission** for my parents/legal guardian/children/personal friend to be involved in my dental care-financially, to make appointments and to have my dental treatment discussed with them. I may change this at any time.

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 Practices from this patient but it could not be obtained because:

_____ Patient refused to sign

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

_____ We were not able to communicate with the patient.

_____ Other (Provide specific details – write on back of acknowledgement)