

Exquisite Dental Care, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient's Name

Date

The *Notice of Privacy Practices* provides information about how we may use and disclose protected health information about you. I have read and understand Exquisite Dental Care, PC *Notice of Privacy Practices*. I understand that Exquisite Dental Care, PC reserves the right to change the *Notice of Privacy Practices*, and that I may contact Exquisite Dental Care, PC at any time to obtain a current copy of the *Notice of Privacy Practices*.

Please release patient's health and financial information to:

- Patient ONLY
- Other

Name

Relationship to Patient

Name

Relationship to Patient

Name

Relationship to Patient

Patient's Signature

Date

FOR OFFICE USE ONLY

Written Acknowledgement Not Obtained

Please document your efforts to obtain acknowledgement & reason it was not obtained.

- Notice of Privacy Practices Given- Patient Unable to Sign
- Notice of Privacy Practices Given- Patient Declined to Sign
- Other Reason Patient Did Not Sign: _____

Office Employee's Signature

Date