RECKER DENTAL CARE

Patient Acknowledgment of Receipt Of Privacy Practices Notice and Consent

I, _____, hereby acknowledge that I have reviewed and received a copy, if requested, of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.
- I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

Yes ☐ No ☐ I give my consent for Recker Dental Care to give my spouse information regarding my treatment and appointments.

Yes ☐ No ☐ I give my consent for Recker Dental Care to give my parents information regarding my treatment, appointments, and insurance and billing.

I also understand that if I have any questions or complaints, I may contact:

Recker Dental Care Compliance Official

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: ____/__/_____

Name: _____
(Printed)

Relationship to Patient: _____

For Office Use Only

☐ Patient refused to sign (date of refusal)___/___/____.

☐ Communication barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other _____

Attempt was made by: _____Date:____/__/_____