ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered and able to read a copy of Johnson Dental's Notice of Privacy Practices.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I understand by signing this form I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. Your office will continue to use my health information in some of these ways: by calling me by first and last name from your waiting room, by mailing reminder appointment cards with reason for visit, by reminding patients needing a pre-medication on reminder cards or confirmation calls, by calling to confirm appointments, and internal audits of patient charts for practice evaluation purposes as described in our Notice of Privacy Practices. I have the right to request alternative means of delivery.

☐ I am signing as a parent/guardian for _____
Patient's name

_____	_____	_____
Print name	Signature	Date

_____Staff 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 this acknowledgement. Date: _____

_____Communication barriers prohibited obtaining acknowledgement.

_____Emergency situation prevented us from obtaining acknowledgement.

_____Other

*****Scanned Copy Serves as an Original*****