Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ______________________________ Date of Birth: ___________________

I have been given a copy of John Powers, DMD *Notice of Privacy Practices ("Notice")*, which describes how my health information is used and shared. I understand that the Practice has the right to change this *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practices:*

____ ______________

Signature of Patient or Personal Representative *Date*

____

Print Name

____

Personal Representative's Title (e.g., Guardian, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

____

____

Completed by:

____ ______________

Signature of Practice Representative *Date*

____

Print Name and Title

File Original in Patient's Health Care Record

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