HIPPA PRIVACY
ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICE

I, _____ (the "patient" or "patient's legal representative"), have been presented with the Notice of Privacy Practice Policy (the "policy") of East Aurora Family Dentistry (the "provider"), and have been offered a copy of such policy to keep for my records.

_____ I hereby acknowledge that I have read the Policy and understand its terms and conditions.

_____ I hereby refuse to acknowledge receipt of the Policy and refuse To read or acknowledge any of the term and conditions of the Policy. I understand that even though I may refuse to sign this Acknowledgement, Provider may still provide treatment to me.

_____
Signature of Patient (or legal representative) Date

For Practice Use Only

I, _____ acting as _____
(Please print full name here) (Please print relationship to or official position with Provider)

For Provider attempted to obtain written acknowledgement of receipt of the Policy of Privacy on _____ but acknowledgement could not be obtained because:

_____ Patient or Patient's legal representative refused to sign.

_____ Patient or Patient's legal representative could not be communicated with Sufficient to obtain acknowledgement.

_____ Emergency circumstances prevented securing acknowledgement.

_____ Other (Please specify)