ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have reviewed a copy of this office's Notice of Privacy Practices. I can request a copy of the HIPAA Privacy Law from my doctor. I agree that Dr. Weinstein may use and disclose my health information to the extent necessary to help with my healthcare or with payment for my healthcare as outlined by the HIPAA Privacy Law. I understand that my health information is private and protected by law. I understand that no unnecessary health information disclosures will be made about me and that my information will not be used for marketing purposes.

____
Print name

____
Signature Date

I authorize and agree that Texas Wisdom Teeth and Dental Implants may disclose my protected health information to the following persons, each of who is directly involved in my care:

1. ______________________ 2. ______________________

3. ______________________ 4. ______________________

Office 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.
_____ Communications barriers prohibited obtaining the acknowledgement.
_____ An emergency situation prevented us from obtaining acknowledgement.
_____ Other (please specify):

____
____
____

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