ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Brinegar Family Dentistry
409 Sixth Street
Jeffersonville, IN 47130

Purpose: This form is used to obtain acknowledgement of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

*****You May refuse to sign this acknowledgement*****

I ________________________________have received a copy of this offices Notice of Privacy Practices. *(please print)*

____
{Signature of Patient or Guardian}

____
Date

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I ________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

________________________	________________________
(Please print name)	Relationship
________________________	________________________
(Please print name)	Relationship
________________________	________________________
(Please print name)	Relationship

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice or Privacy Practices but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ A emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)