ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES & CONSENT TO DISCLOSE INFORMATION

My signature confirms that I have been informed of my rights to privacy regarding my protected health information (PHI), under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been given the right to review and receive a copy of such Notice of Privacy Practices.

Patient Name: ________________________________ **Date of Birth:** ____________

Signature: ___________________________________ **Date:** ___________________

OR

Signature of Personal Representative: _____________________________________

_____ **Parent** _____ **Guardian** _____ **Power of Attorney** **Other:** ________

Dependent family members also covered by this acknowledgement:

____

I authorize Timberview Family Dental to disclose my health and/or account information

to: _____________________ Relationship to Patient: __________ Phone #:_________

Please Note: It is your right to refuse to sign this Acknowledgement

To be completed by office personnel if form is not signed:

I, ______________________________, attempted to obtain the patient's acknowledgement of receipt of Notice of Privacy Practices, but was unable to do so. Reason acknowledgement and consent not obtained: ________________________________

Employee Signature: ____ Date: __________________________