

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date: _____

You have the right to refuse to sign this Acknowledgement

I, _____, have
(Signature of Patient)

received a copy of this office's **NOTICE OF PRIVACY PRACTICES** required by federal law.

Print Patient's Name

Patient's Signature

FOR OFFICE USE ONLY

On the date above we made a "good faith effort" to obtain written acknowledgement of receipt of our **NOTICE OF PRIVACY PRACTICES**. We were unable to obtain acknowledgement for the following reason:

- Patient refused to sign
- Other _____

(Possible reasons: Language difficulty, communication barriers, dental emergency)

(Print Name)

(Signature of employee attempting to gain acknowledgement)