AFFORDABLE FAMILY DENTAL
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (Print Name) _____, have received a copy of this office's Notice of Privacy Practices and understand that I am giving my consent to use and disclosure of my protected health information (PHI) to carry out treatment, payment activities and health care operations.

PRINT NAME _____
SIGN NAME_____ DATE_____

If consent is signed by a personal representative on behalf of the patient, complete the following:
PRINT NAME_____
SIGN NAME_____ DATE_____

You may refuse to sign this acknowledgement. You are entitled to a copy of this consent if you so desire. Refusal to sign this form will prohibit us from completing certain tasks on your behalf such as filing insurance, confirming your appointment, calling in prescriptions, arranging appointments for you at other offices and mailing re-care cards, etc.

Office Use Only: We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:
( ) Individual refused to sign ( ) Communication barriers prohibited obtaining acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement ( ) Other:

ALTERNATIVE PERSON COMMUNICATION AUTHORIZATION FORM
Patient Name: _____SSN:_____

When it comes to your medical treatment, we strive to communicate with you in a timely and as professional manner as possible. There are certain occasions when family members, friends or others might be involved in your case as a patient and you will want our office to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information (PHI). Please list below any other people with whom you authorize our office to discuss aspects related to your care.

Name: _____ Relationship _____ Phone:_____

Name: _____ Relationship _____ Phone:_____

Name: _____ Relationship _____ Phone:_____

Do we have permission to leave detailed messages on voice mail or answering machine?
YES _____ NO _____
Patient/Responsible Party Signature: _____
Date: _____