Wycliff Family Dentistry, LLC

ACKNOWLEDGEMENT OF RECEIPT OF

HIPAA NOTICE OF PRVACY PRACTICES

("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

Patient Name _____

Patient Signature_____ Date _____

OR

Signature of Personal Representative _____

Authority of Personal Representative to Sign for Patient (Check One)

☐Parent ☐Guardian ☐Power of Attorney ☐Other

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

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Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other_____

_____ _____

Staff Member Signature Date