Patient Acknowledgement of Receipt of Privacy Practice Notice

Dunwoody Dental

I, _____, hereby acknowledge that I have received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand t hat the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Jamie Matherne, Office Manager at Dunwoody Dental

Patient or Personal Representative

Signature:_____ Date_____

Name:_____ Relationship_____

Patient Authorization for Disclosure of Protected Health Information

_____**Home telephone**_____

_____O.K. to leave a message with information

_____Leave a message with call back number only

_____**Work telephone**_____

_____O.K. to leave a message with information

_____Leave a message with call back number only

_____**Text Communication**

_____O.K. to text to this number_____

_____**E-mail Communication**

_____O.K. to email to the following email address_____

_____**List two individuals authorized for communication**

1. _____ Phone number_____

2._____Phone number_____