CARTER AND HOFF DENTISTRY

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You may refuse to sign this Acknowledgement"

I have received a copy of the "Notice of Privacy Practices" for Carter and Hoff Dentistry.

_____ _____
Please print name Signature

_____ _____
Relationship to patient Date

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In accordance with our "Notice of Privacy Practices," we may disclose your health and financial information to family members, relatives, friends, or other persons indentified by you. Please list the names of ALL persons you would like to permit to have access to your health and financial information.

Your Spouse _____

Parent/Guardian _____

Parent/Guardian _____

Other _____ Relationship_____

Other _____ Relationship_____

We routinely disclose health, contact, and insurance information to doctors' offices in which our doctors refer you to for additional treatment. To these offices and to your contacts listed above, we may use the following methods of information transmission: personal conversation, hand delivery, written mail, phone, voicemail, fax, and email.

Do you agree to all of the above named methods of transmission? Y / N

If no, please write which transmission method(s) you do not want us to use:

_____

I understand that this agreement remains valid unless I provide written notice to revoke or change it.

Patient Signature_____ Parent/Guardian Signature_____
Date_____ (If patient is a minor)

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (Please specify)

_____
_____