HOGAN FAMILY Dental

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT OF RECEIPT

[For Office Use Only] Acknowledgement of Receipt was attempted, but not obtained because:

_____

Signed: _____ Date: _____

You may refuse to sign this Acknowledgement.

I hereby acknowledge that I have received a copy of the Hogan Family Dental HIPAA Notice of Privacy Practices.

_____ Date_____

Signature of Patient or Patient's Representative

Printed Name of Patient(s): _____

Printed Name of Patient Representative: _____

Relationship to Patient: _____

Use and Restriction of Protected Health Information

In general, HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual also has the right to request confidential communications or that communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone_____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave a message

☐ Work Telephone_____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave a message

☐ Cell Phone _____
- ☐ Leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave a message
- ☐ Send messages by text

☐ Written Communication
- ☐ Mail to my home address
- ☐ Mail to my work/office address
- ☐ Do not mail
- ☐ Email to _____
- ☐ Fax to this number _____

☐ Verbal Communication
- ☐ May release information verbally to:

_____

_____

_____

_____

The patient is responsible to provide updates or changes to this information in writing.

_____ Date_____

Signature of Patient or Patient's Representative (as above)