

HIPAA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

The undersigned acknowledges access to a copy of the currently effective Notice of Privacy Practices for Thomas Orthodontics this _____ day of _____, 20____. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name/Relationship to Patient

Please sign your name

If you are the legal representative of the patient, please print the patient's(s) name(s)_____.

Please list all family members that you wish to have access to his/her records, if no one other than yourself please put N/A.

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Lisa Lockwood.

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment	_____
I could not communicate with the patient	_____
The patient refused to sign	_____
The patient was unable to sign because	_____
Other (please describe)	_____

Signature of privacy officer