Children's Dentistry
OF COUNCIL BLUFFS

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Patient's Last Name: _____ First Name: _____ Date of Birth: _____

You may refuse to sign this agreement.

I give consent for the Use and Disclosure of Health Information of myself and/or my dependent(s) for the purpose of the Treatment, Payment or Communication between other healthcare professionals.

I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing the condensed form.

_____
Name of Parent/Guardian

_____ _____
Relationship to Patient Signature of Parent/Guardian Date:

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): _____