HIPAA Acknowledgement and Consent

The undersigned understands that our practice is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Patient Name: _____Date of Birth_____

Patient Signature: _____

Patient Representative _____Relationship to Patient_____

Please check all that may apply:

- ☐ Office may leave message on answering machine/cell phone.
- ☐ Office may call cell/home phone_____.
- ☐ Office may text cell phone _____.
- ☐ Office may leave message with spouse and /or significant other_____.
- ☐ Office may email patient _____.
- ☐ **Office should only speak with patient.**
- ☐ Information may be given to other family member.

_____.

The Lee Center for Family & Cosmetic Dentistry office use only:

An Attempt was made to obtain a written acknowledgment of receipt of our Notice Privacy Practice, but the acknowledgment could not be obtained because:

- ☐ The individual refused to sign.
- ☐ Communication barrier prevented our obtaining the acknowledgement
- ☐ An emergency situation prevented our obtaining the acknowledgement.
- ☐ Other (please specify)

_____

Employee Signature_____Date_____