

**WHITE RIVER FAMILY DENTAL**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
and CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION**

\*You may refuse to sign this acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

I consent for disclosure of my Protected Health Information, including my name, diagnosis(es), test results and dates of service.

You may disclose information to the following family members and/or non-family members:

<b>Name</b>	<b>Phone Number</b>	<b>Relationship</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

You may leave Protected Health Information on my answering machine/voicemail. **YES**\_\_\_\_\_ **NO**\_\_\_\_\_

Phone Number: \_\_\_\_\_ Additional Phone Number: \_\_\_\_\_

\_\_\_\_\_  
**Patient's Printed Name**

\_\_\_\_\_  
**Patient's Date of Birth**

\_\_\_\_\_  
**Patient's Signature (Parent or 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
- \_\_\_\_\_ Communications barriers prohibited obtaining the acknowledgement
- \_\_\_\_\_ An emergency situation prevented us from obtaining the acknowledgement
- \_\_\_\_\_ Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_