Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment.

I, _____ have received a copy of the NOTICE OF PRIVACY PRACTICES. I hereby authorize you to share/disclose my health information with the following persons/parties.

_____ _____

_____ _____

_____ _____

_____

Patient or Parent/Guardian Signature

_____ _____

Patient Name *Name of Legal Guardian*

If you are the legal representative of the patient please print the patient's name(s) and describe your authority/relationship.

_____

_____

* *

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES document, 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) _____

_____

SMILE DESIGN STUDIO
for the health...for the beauty...of your smile

1331 S. International Pkwy., Suite 2271, Lake Mary FL 32746
www.smilesbydrfalco.com • **407-804-0770** • office@smilesbydrfalco.com