HESTER PEDIATRIC DENTISTRY P.A.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of Hester Pediatric Dentistry, PA Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I, hereby, consent to the use and disclosure of my health information for the purposes and activities under the federal law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (239)234-6325.

Patient's Name (please print): _____ Date: _____

Signature (if minor, parent or guardian): _____ Date: _____

You may refuse to sign this acknowledgement

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 acknowledgement

☐ Other (Please Specify)

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