Schaffner Family Dental
Acknowledgment of Receipt of
HIPAA Notice of Privacy Practices
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to sign for patient (check one):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please note: It is your right to refuse to sign this acknowledgement.

OPTIONAL: Dental Information Sharing and Disclosure

I authorize Schaffner Family Dental to share or disclose any and all of my dental information with those individuals listed below:

_____

This authorization will expire on the following:
____ Date: _____
____ Event: _____
_____

_____ _____
Signature of Patient Date

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

___ An emergency prevented us from obtaining acknowledgement.

___ A communication barrier prevented us from obtaining acknowledgement.

___ The individual was unwilling to sign.

___ Other: _____

_____ _____
Staff Member Signature Date