Sturbridge Dental
Town Dental Partners, LLC

_____ _____

Patients First Name, Middle Initial **Patients Last Name**

Acknowledgement Of Receipt Of Notice of Privacy Practices

The following person (or class of persons) may receive disclosure of protected health information about me:

Name

Address

City, State, Zip Code

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGINING- note that signature is required in two places. *

_____ _____ _____

Signature of Individual (The person about whom the Information relates) **Date of Individuals Signature** **Date of Birth**

_____ _____ _____

Signature of Guardian **Date of Guardians Signature** **Description of authority to Act for the Individual**

OFFICE USE ONLY- We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because- (circle what applies)

- Individual refused to sign
- Communication barriers prohibited obtaining an acknowledgment
- An emergency situation provided us from obtaining an acknowledgment
- Other (please specify)-

_____ _____ _____

RECEIVED BY PROCESSED BY DATE