Patient Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:	Date of Birth:

HIPAA Authorization

I hereby acknowledge that I have reviewed and received a copy of Augusta Dental's *Notice of Privacy Practices explaining*:

- How Augusta Dental will use and disclose my protected health information,
- My privacy rights with regard to my protected health information, and
- Augusta Dental's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact Augusta Dental at 207.622.1488 or contactus@augustamedental.com.

I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Their contact information can be found at www.hhs.gov/about/contactus/index.html.

I hereby give authorization to the following people to access my personal health information:

_____ _____ _____

Signature

_____ _____

Patient / Parent / Legal Guardian Signature Date

FOR OFFICE USE ONLY

We made a good-faith effort to obtain an acknowledgment of_____ 's receipt of our Notice of Privacy Practices. In spite of these efforts (check all that apply):

☐ Patient refused to sign (date of refusal)_____

☐ Communication barriers prohibited obtaining an acknowledgment

☐ An emergency situation prevented us from obtaining an acknowledgment

☐ Other_____

Attempt was made by:_____ Date:_____