Mark R. Stephenson, DDS

Patient Name _____ Account # _____

Notice to Patient:

We are required by law to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

Name _____ _____ _____
LAST FIRST MID.

Signature _____

Date _____

For official use only:

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient, but it could not be obtained because

- ☐ Patient refused to sign
- ☐ Due to emergency situation, it was not possible to obtain an acknowledgment
- ☐ We weren't able to communicate with the patient
- ☐ Other (Specify)

_____

_____

_____

Employee _____

HIPAA Acknowledgment of Receipt of the Notice of Privacy Practices
This form does not constitute legal advice and covers only federal law