Acknowledgement of Receipt of Notice of Privacy Practices

CENTRAL FLORIDA ENDODONTICS LLP

*** You May Refuse to Sign This Acknowledgement ***

I have been given the opportunity to review this office's Notice of Privacy Practices and been given an opportunity to receive a written copy.

I. Print Name of Patient: ______________________________ DOB: __________

Print Name of Authorized Representative: ______________________________

II. If the patient is a minor or unable to sign, please complete the following:

☐ Patient is a minor: ________ years of age

☐ Patient is unable to sign because: ______________________________

III. Patient's protected information may be disclosed to the following:

Name: ______________________________ Relationship: __________

Name: ______________________________ Relationship: __________

Name: ______________________________ Relationship: __________

IV. Patient Signature: ______________________________ Date: __________

or

Authorized Representative: ______________________________ Date: __________

V. Authorized to sign on behalf of the patient

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other

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