

University Periodontal Associates, Inc.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices.

I authorize release of health information to the following family member, friend, or other individual:

\_\_\_\_\_  
**Referring Dentist/ General Dentist**

\_\_\_\_\_  
**Relative**

\_\_\_\_\_  
**Relationship**

I authorize release of necessary information to my insurance company to obtain benefits. \_\_\_\_\_

**Initials**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**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
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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