



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

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

(Please Print Name)

(Signature)

(Date)

In addition, as of the date indicated above, I hereby request and grant Cornerstone Dental Associates, PLLC permission to share my protected health information with the person(s) or organization(s) listed below.

Spouse: _____ Phone number: _____

Parent or child: _____ Phone number: _____

Other: _____ Phone number: _____

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)