

Harvard Dental Group

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

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

In accordance with federal law, I, _____, have received a copy of this office's Notice of Privacy Practices.

Do you give us permission to confirm appointments by phone, message, and by mail? ☐ Yes ☐ No

Do you give us permission to discuss your treatment, insurance coverage, and treatment plan with a family member? ☐ Yes ☐ No

If so, please list the names of those you authorize our office to discuss this information with:

Print Patient's Name

Patient / Responsible Party's 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 ☐ Communication Barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

(Please turn over and complete back-side)