ABERT LEE, DDS

Acknowledgement of Receipt of Privacy Practices Notice

We respect the privacy of our patients and we will not disclose your records to others unless you direct us to or unless the law authorizes or requires us to. Our Notice of Privacy describes in detail how your health information is used and disclosed and how you can access your information. By signing this form, you are acknowledging receipt of the Notice of Privacy Practices.

Section A: Information

Print Name: ___________________________________

Additional Disclosure Authority		
In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below. Check one.		
Any member of my immediate family	☐ Yes	☐ No
Spouse only	☐ Yes	☐ No
Other (specify):	☐ Yes	☐ No

Section B: Acknowledgement of Receipt of Privacy Practices Notice I acknowledge that I have received a Notice of Privacy Practices from Abert Lee, DDS.

Signature: ____ Date: _________________

If a parent or guardian signs this authorization on behalf of the patient or to include any minor children, complete the following:

Names(s) of children: ____

Relationship to Patient: ____

Section C: Good Faith Effort to Obtain Acknowledgement of Receipt (*To be completed by staff):*

Describe your good faith effort to obtain the individual's signature on the form: ________________

____

Describe the reason why the individual would not sign this form: _____________________________

Name of Staff Member: ____ Date: ________________