Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of River City Dental. I hereby authorize, as indicated by my signature below, River City Dental to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added / Removed:_____

2. _____Date Added / Removed: _____

3. _____Date Added / Removed: _____

4._____Date Added / Removed: _____

May our office send you an unencrypted email message: Yes _____ NO _____

May our office send you an unencrypted text message: Yes _____ NO _____

In case of an emergency please contact:

Name: _____

Home # _____ Work # _____ Cell # _____

Relationship to patient: _____

*** * ***

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 acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____