ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
Arocha and Jaquez, DMD, PA

We are required to display a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge review of the notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have viewed a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

_______ The patient refused to sign

_______ Due to and emergency situation it was not possible to obtain an acknowledgement.

_______ We were not able to communicate with the patient.

_______ Other (please provide specific details)

Employee signature

Date