Cornerstone Family Dentistry, LLC

Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Cornerstone Family Dentistry. I hereby authorize, as indicated by my signature below, Cornerstone Family Dentistry 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 check your preferred means of communication:

□ You may contact me at my home telephone number: _____
□ You may contact me on my mobile telephone number: _____
□ You may contact me on my work telephone number: _____
□ You may send me an email at: _____
□ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. _____ Relationship: _____ Date ___/___/____
added/removed

2. _____ Relationship: _____ Date ___/___/____
added/removed

3. _____ Relationship: _____ Date ___/___/____
added/removed

****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: _____