



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

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

By my signature below, I acknowledge that I have received either a paper or an electronic copy of the **HIPAA NOTICE OF PRIVACY PRACTICES** for **ATLANTA CENTER FOR ADVANCED PERIODONTICS, COSMETIC & IMPLANT DENTISTRY-MIDTOWN, LLC** (the "Practice"). I also understand that I am entitled to receive a paper copy of the **HIPAA NOTICE OF PRIVACY PRACTICES** upon request, even if I have previously agreed to receive only an electronic copy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***If applicable:***

Representative Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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**PERMISSION TO DISCUSS TREATMENT OR BILLING INFORMATION**

By my signature below, I authorize the Practice to discuss my treatment and/or billing information with:

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***If applicable:***

Representative Name: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

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**FOR OFFICE USE ONLY:** *Only if the acknowledgment above is not signed by the patient or the patient's representative.*

A good faith effort was made to obtain a written **ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES**, but could not be obtained because *(please check as appropriate)*:

- \_\_\_\_\_ Refusal by patient or patient's representative.
- \_\_\_\_\_ A communication barrier prevented obtaining a signature.
- \_\_\_\_\_ An emergency situation prevented obtaining a signature.
- \_\_\_\_\_ Other: \_\_\_\_\_.

Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_