Acknowledgement of Receipt of Notice of Privacy Practices

****You May Refuse to Sign This Acknowledgement****

Patient's Name_____ **Date**_____

(A) I have received a copy of Prestonwood Dental's notice of privacy practices.

(B) I request and authorize the office of Shweta G. Daftary, DDS dba Prestonwood Dental to disclose my protected health information as described below.

Persons	**Relationship**
_____	_____
_____	_____

Specific Description of Information to be used or disclosed (Check one or more):

- ☐ My Treatment Plan
- ☐ My Claims Information
- ☐ My Dental Insurance
- ☐ My Account Balance or other Financial Related Matter
- ☐ My Appointment Changes/Confirmations with this office
- ☐ Other (Please specify)_____

Signature_____ **Date**_____

For Prestonwood Dental 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):_____

_____

_____

(Please Turn Over)