Virginia Family Dentistry
A TEAM APPROACH TO DENTAL CARE

Acknowledgement of Receipt of Notice of Privacy Practices

****You may Refuse to Sign This Acknowledgment****

I have been notified of this office's Notice of Privacy Practices.

Print Patient Name: _____

Signature: _____

If you are the patient's personal representative:

Relationship to Patient: _____

Print Name: _____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Employee Initials: _____ Date: _____

Please list on reverse side any individuals you would like us to share your information with.

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I, _____, sgive permission to Virginia Family Dentistry to discuss and release my protected health information to the following individuals listed below:

Name(s):	*Relationship:*

This authorization shall remain in effect until I revoke it. I understand I may revoke this authorization at any time by notifying Virginia Family Dentistry, preferably in writing.

Print Patient Name: _____

Signature: _____

If you are the patient's personal representative:

Relationship to Patient: _____

Print Name: _____