Dana F. Morris D.M.D., LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, _____ (Patients/Legal Guardian/Caregiver Name), have been given the opportunity to review and/or receive a copy of this office's "Notice of Privacy Practices" Policy.

_____ _____

Patient's Name (Please PRINT) Parent/Legal Guardian/Caregiver Name (Print)

_____ _____

Patient/Parent/Legal Guardian/Caregiver (SIGNATURE) Today's Date

Disclosure Note: You may refuse to sign this acknowledgement

Please Check All that Apply

_____You may leave a Protected Health Information (PHI) on my answering machine or voicemail

Phone Number_____

_____ Other: _____

You may select which types of PHI you will allow us to disclose to the people below:

A. ALL PHI (medical info AND financial info)

B. Medical information only

C. Financial information only

_____ You may disclose information to my family members and/or non-family members. Please list Name, Phone Number, and Relationship.

NAME PHONE NUMBER RELATIONSHIP PHI ALLOWED

1. _____

2. _____

3. _____

OFFICE USE ONLY:

_____Individual refused to sign

_____Responsible party not present

_____Communication barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented obtaining acknowledgement