Children's Dental Associates, P.C.

Your Privacy is Important to Us!

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of the Notice of Privacy Practices of Children's Dental Associates. I hereby authorize, as indicated by my signature below, Children's Dental Associates to use and disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

(Parent or Legal Guardian) Signature Print Name

_____ _____

Relationship to Child/Children Date

Please check any of your preferred means of communication:

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

Please list authorized persons with whom we may discuss Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Relationship to Child/Children _____
2. _____Relationship to Child/Children _____
3. _____Relationship to Child/Children _____
4. _____Relationship to Child/Children _____
5. _____Relationship to Child/Children _____

If the parent or legal guardian wants to make any changes to this list, a new form must be completed. This document does not expire until the Practice is notified in writing by the parent/legal guardian.

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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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining acknowledgement
- o An emergency situation prevented us from obtaining the acknowledgement
- o Other (Please Specify) _____

Staff Persons Initials _____