Johns Dental, LLC

Acknowledgment of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of the HIPAA Notice of Privacy Practices document. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Johns Dental, LLC and of my rights with my health information. I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____
Patient's Printed Name

_____ _____
Patient's Signature Date

_____ _____ _____
Signature of Patient's Representative Relationship Date
If patient is unable to sign

1. Do you allow us to contact you by phone calls, text messages and email regarding appointments or any other matter that may arise? ☐ **Yes** ☐ **NO**

2. Can we leave a message for you on the numbers you have provided us? ☐ **Yes** ☐ **No**

Sharing Protected Health Information with Family and Friends

Please list all family members you give us consent to share your health information with.

Name	Relationship
1. _____	
2. _____	
3. _____	

TO BE COMPLETED BY DENTAL OFFICE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?
☐ Yes ☐ No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or unwilling to sign this form:

_____

_____

_____