West Michigan Dental Professionals

Your Privacy is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

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

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communication:

☐ You may contact me at my home telephone number_____

☐ You many contact me on my mobile telephone number_____

☐ You may contact me on my work telephone number_____

☐ You may send me an email at:_____

☐ Other_____

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

1._____Date Added/Removed:_____

2._____Date Added/Removed:_____

3._____Date Added/Removed:_____

4._____Date Added/Removed:_____

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

☐ Other (Please Specify) _____

Staff Person Initials _____