Acknowledgement of Receipt of Notice of Privacy Practices

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

Please check your preferred means of communication:

☐ You may contact me at my home telephone number: _____

☐ You may contact me on my mobile telephone number: _____

☐ You may contact me on my work telephone number: _____

☐ You may send me an unencrypted email/text message at: _____

☐ Other _____

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

1. _____ Date Added / Removed: _____

2. _____ Date Added / Removed: _____

3. _____ Date Added / Removed: _____

I have received a copy of Island Dentistry's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

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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:

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