

Burke Sedation Dentistry

Anthony N. Hoang, DMD & Associates, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

****You May Refuse to Sign This Acknowledgment****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}

Relationship

{Please Print Name}

Relationship

{Please Print Name}

Relationship

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

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