Garrett K. Piskor D.M.D., P.C.

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(Adult)

I have received a copy of the Notice of Privacy Practices of Garrett K. Piskor D.M.D., P.C. I hereby authorize, as indicated by my signature below, Garrett K. Piskor D.M.D., P.C. 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 may contact me on my mobile telephone number _____

☐ You may contact me on my work telephone number _____

☐ You may send me an email at: _____

☐ You may leave detailed messages on voice mail of above numbers, regarding x-ray results and/or appointments needed.

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: _____

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

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (Please Specify) _____

Staff Person Initials _____