Khisti Dental Center

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

_____ _____ _____

Please Print Name Signature Date

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information as indicated below*

ANY MEMBER OF MY IMMEDIATE FAMILY	_____YES	_____NO
OTHER (Specify)	_____YES	_____NO
_____	_____YES	_____NO
_____	_____YES	_____NO
_____	_____YES	_____NO

*Failure to check any individual box does not constitute permission, consent, or authorization to disclose my personal health information. Each item of authorization must be signed or otherwise acknowledged.

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 barrier prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement ___ Other (specify) _____

POS® Reorder # 1418006