

# Acknowledgement of Receipt of Notice of Privacy Practices

Patient(s) Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

I acknowledge and understand by signing below, I have been informed of, and offered a copy of **Aiea Pediatric Dental Center** 'Notice of Privacy Practices'.

I understand that according to the policies of **Aiea Pediatric Dental Center**, information that may be considered 'Protected Health Information' may be disclosed for the following reasons, including but not limited to; making, confirming and rescheduling appointments, obtaining contact information, post operative follow up calls, referrals to other providers, and obtaining payment for services provided.

**I understand that unless I inform Aiea Pediatric Dental Center of restrictions regarding disclosure of my or my child's 'Protected Health Information', disclosure will be at their discretion, in accordance with the Health Insurance Portability & Accountability Act of 1996.**

\_\_\_\_\_  
Signature of Patient or Parent if patient is a minor

\_\_\_\_\_  
Date

**Comments:**

\_\_\_\_\_

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**If a personal representative signs this acknowledgement on behalf of the patient, please complete the area below:**

\_\_\_\_\_  
Personal Representative's Name

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness for Aiea Pediatric Dental Center

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## For Office Use Only

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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 barrier prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (please specify). \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature of Dental Office Staff: \_\_\_\_\_

"I certify that I informed the patient, offered a copy of the 'Notice of Privacy Policies', and accepted this document in return."