



Acknowledgement of Receipt of Notice of Privacy Policies

Adult

1630 NW Broad St. Ste. 101, Murfreesboro, TN 37129 • 615.896.0608 • stonesriverdental.com

I hereby authorize, as indicated by my signature below, 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 _____

You may contact me at the following:

- ☐ Home phone number _____
- ☐ Cellphone number _____
- ☐ Work phone number _____
- ☐ E-Mail _____
- ☐ 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: _____
4. _____ Date Added / Removed: _____
5. _____ Date Added / Removed: _____

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
- ☐ An emergency situation prevent us from obtaining the acknowledgement
- ☐ Other (please specify) _____

Staff Person's Initials _____