

Acknowledgement of Receipt of Notice of Privacy Practices

Release of Protected Health Information (PHI) to Others:

Unless objected below, we have permission to release your protected health information to anyone involved in your protected health information to and to anyone involved in you care such as Parents, Guardians, Foster Parents, or your other care providers. If you object, please list the name(s) of the person(s) and the type of information you would like limited access to: Type of Info: ____ By signing below, I acknowledge that I have been provided with a copy of the Neibaur Family Orthodontics "Notice of Privacy Practices" and have therefore been advised of how health information about me may be used and disclosed by Neibaur Family Orthodontics and how I may obtain access to and control this information. Print Name of Patient or Representative Signature of Patient or Representative Date Description of Representative's Authority Home# Cell# Work# THIS SECTION WILL BE COMPLETED IF THE WRITTEN ACKNOWLEDGEMENT NOT OBTAINED (completed by office staff) We have mad a good faith effort to obtain asn individual's acknowledgement, but the acknowledgement was not obtained for the following reason(s): The individual refuses to sign or otherwise fails to provide an acknowledgement The individual was mailed a copy of the notice and did not mail back his or her receipt of acknowledgement Other Completed by: ______ Date: _____