Gilrain and Brooks, D.D.S., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices.**

_____
Patient Name (Please Print)

_____ _____
Signature Date

I authorize the office of Gilrain & Brooks, D.D.S., P.C., to share and discuss my protected health information with the following persons:

_____ _____please initial
Name and Relationship

_____ _____please initial
Name and Relationship

_____ _____please initial
Name and Relationship

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental 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
- A communication barrier prevented us from obtaining acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other:_____