Pediatric Dentistry of Portland, LLC

ACKNOWLEDGEMENT FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES

(YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT)

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

Please Print Patient Name_____
Parent/Guardian Signature _____
Date _____

Pediatric Dentistry of Portland, LLC may leave protected Health Information (including patient's name, diagnosis, date of service) on the following:

- o Answering machine/voicemail: Phone Number_____
- o Text message: Phone Number _____
- o Email for dental appointment: email address:_____
- o Other _____

AUTHORIZATION TO RELEASE INFORMATION

This section is used to obtain authorization to release information regarding you and/or your child covered under the Privacy Act to people other than yourself. I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself and/or my child(ren).

_____

Print Name Relationship Phone Number

_____

Print Name Relationship Phone Number

_____

Print Name Relationship Phone Number

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:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify):

_____