

Katherine L. Fry, DMD PC
Diplomate, American Board of Endodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgment***

I acknowledge receipt of the Notice of Privacy Practices form, which details how Protected Health Information may be used and disclosed, and how I may access that information.

Print Name: _____

Signature: _____

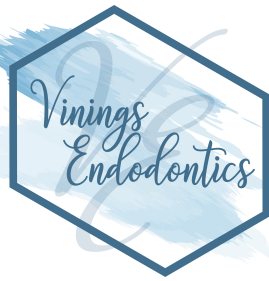
Date: _____

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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (cont'd)

You may refuse to sign this acknowledgement

Name: _____

DOB: _____

Social Security #: _____

I authorize the following methods of communication for reminders of my appointments and/or discussion of my account:

- ☐ Open Correspondence
- ☐ Messages at work Wk # _____
- ☐ Messages on cell Cell # _____
- ☐ Text Messages Cell # _____
- ☐ Messages at home Hm # _____
- ☐ Email Email _____
- ☐ Postcard _____

I authorize person(s) to whom my medical information may be released:

_____	_____	_____
Name	Relationship	Contact #
_____	_____	_____
Name	Relationship	Contact #
_____	_____	_____
Name	Relationship	Contact #

I have read the consent of this authorization form and I agree with all statements made. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature of Patient (Guardian) _____ Date _____

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