The Dental Comfort Zone respects your privacy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I have received a copy of the Dental Comfort Zone Notice of Privacy Practices

Signature_____ **Date**_____

Upon request, a copy of our Notice of Privacy Practices will be provided for you review.

I wish to be contacted in the following manner (check **all** that applies):

Home Telephone Number_____

Check off: ____Leave message with detailed information.
____Leave message with call back number.

Work Telephone Number_____

Check off: ____Leave message with detailed information.
____Leave message with call back number.

Cell/Other Number_____

Check off: ____Leave message with detailed information.
____Leave message with call back number.

Written Communication

Check off: ____Mail to home address.
____Fax to this number_____

I hereby give permission for the Dental Comfort Zone to disclose information regarding my treatment to:

Check off:

____Spouse ____Son/Daughter ____Other Relative ____Other healthcare provider taking part in your medical/dental care.

In signing this, I authorize my dental records to be faxed or mailed upon my request.

Name_____ Date of Birth_____

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
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)_____