



Dr. Andrew J. Dvnoch, DDS | Dr. Barbora H. Valerio, DDS

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE

I, _____, acknowledge that I have received a copy of this dental practice's HIPAA Notice of Privacy Practices.

(Patient Signature) (Date)

-OR-

(Signature of Personal Representative; see below) (Date)

Parent Guardian Power of Attorney Other: _____

It is within your right to refuse to sign this acknowledgement.

I certify that I am 18+ and would like to grant permission for the following persons to see my: (check all that apply)

- Appointment date and times
- Treatment plans and referrals
- Financial and billing information
- None of the above
- Any other pertinent dental health information related to treatment at this office

Please list person(s) below:

_____ (Patient initial)

I understand that permission will remain in effect unless a written cancellation has been provided to Linden Oaks Dental.

Dental office use only:

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices but it could not be obtained because:

- An emergency prevented us from obtaining acknowledgment. The individual was unwilling to sign.
- A communication barrier prevented us from obtaining acknowledgment.
- Other: _____.

(Staff Member Signature)

(Date)