Linden Oaks DENTAL

Dr. Andrew J. Dvonch, DDS | Dr. Stephanie B. Erbland, DMD

Dr. Tejal V. Shastri, DDS

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.

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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)