Mountain Laurel Dental

Acknowledgement of Receipt of Notice of Privacy Practices*

*** You may refuse to sign this Acknowledgement**

I, ________________________________, have been afforded the opportunity to read this office's Notice of Privacy Practices.

Please Print Name ________________________________ **Relation to Patient (self, parent, or legal guardian)** ________________________________

Signature ________________________________ **Date** ________________________________

PATIENT AUTHORIZATION

In order for our practice to comply with HIPAA Federal Regulations, we ask that you read and sign this so that we may provide you with the best care and treatment possible, while safeguarding your privacy,

If you have family and/or a friend that will be calling requesting information, this MUST be signed by you, or no information regarding your care will be given to anyone other than yourself.

I authorize Dr. Leppard to release my medical information to my personal patient representative(s).

Name of personal representative: ________________________________
Date: ____________________ Relationship: ____________________
Contact #: ____________________ Contact #: ____________________

Name of personal representative: ________________________________
Date: ____________________ Relationship: ____________________
Contact #: ____________________ Contact #: ____________________

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)

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