ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ D.O.B. _____

I authorize Cove Family Dental to utilize and share my health information for treatment, billing and healthcare operations in compliance with the HIPAA Omnibus Rule. I understand that Cove Family Dental has the right to change this notice at any time. I may obtain a copy of this policy by contacting the HIPAA Compliance Officer at Cove Family Dental at 254-547-6453.

PLEASE NOTE: If you would like for your spouse or family members to receive your personal health information, please list their names below. *(This includes step parents, grandparents and any care takers who can have access to this patient's records):*

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Communication from office regarding labs, medications, test results and appointment reminders please check all that apply:

___ May leave message on voicemail

___ May leave message with family member or whomever should answer phone over age 18

___May send an email if requested by me _____

Date: _____ Time: _____ a.m./p.m.

Printed Name: _____

Signature: _____
(Patient/ Representative/ Spouse/ Financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

_____