Robert Silverstein, DMD, MS, PA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

For Patient: _____

I have received a copy of this office's Notice of Privacy Practices.

I also give my consent to share my/the patient's health related information with the following people (circle all that apply):
Mother / Father / Son(s) _____ / Daughter(s) _____ /
Grandmother _____ / Grandfather _____ / Other _____

If the patient is a minor: By signing below, I attest that I have legal custody of the above named patient.

_____
Please Print Name

_____
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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____