ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the office's Notice of Privacy Practices. Wisdom Teeth and Beyond Oral Surgery PLLC provides this form to comply with the HIPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations.
You have the right to request that we restrict how your protected health information is used or disclosed for treatment,
payment, and healthcare operations.

____ ___________________________
Signature of Patient or Legally Authorized Representative Date

____ ___________________________
Print Name of Patient or Legally Authorized Representative Legal Relationship to Patient

I give permission for Wisdom Teeth and Beyond Oral Surgery PLLC to:
□ Call/leave message at my home telephone number: ______________________________
□ Call/leave message/text on my mobile number: _________________________________
□ Call/leave message on my work number: _______________________________________
□ Other:

I give permission for you to speak with these individuals about my care:
(Note: Please notify us if you wish to make a change in the future.)

Name:______________________________Relationship: _______________Phone Number: __________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~ Office Use Only ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to:
□ Patient/Representative refused to sign
□ Communication barriers prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please Specify): ____
Staff Initials: ______________
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