ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Daniel Shelby, DMD
400 E. Watauga Avenue
Johnson City, TN 37601

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of Daniel Shelby, DMD *HIPAA Notice of Privacy Practices*.

I understand that Daniel Shelby's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Daniel Shelby's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Daniel Shelby's *HIPAA Notice of Privacy Practices*, I may contact Daniel Shelby, DMD (423) 926-4867.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that [NAME OF PRACTICE] will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding [NAME OF PRACTICE]'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask [CONTACT PERSON], noted above, for assistance.

_____ _____
Patient Signature Date

_____ _____
Signature of Personal Representative Print Name of Personal Representative

_____
Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Daniel Shelby, DMD's office made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Daniel Shelby, DMD was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID