



## Acknowledgement Of Receipt Of Notice Of Privacy Practices

**Purpose:** This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**\*\* You may refuse to sign this acknowledgement\*\***

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

First Name

Last Name

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date Of Birth*

**I authorize Eastern Carolina Dental to do the following: (Check all that apply)**

- Leave a message on my answering machine/voice mail
- Leave a message with a family member.
- Leave a message via e-mail.
- Contact you via text message.

## Authorization To Release Information

**Purpose:** This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, \_\_\_\_\_, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

\_\_\_\_\_  
*Name (Printed)*

\_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Name (Printed)*

\_\_\_\_\_  
*Relationship*

\_\_\_\_\_  
*Name (Printed)*

\_\_\_\_\_  
*Relationship*

## 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)*

\_\_\_\_\_  
\_\_\_\_\_