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every tiny tooth is precious :)

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal privacy law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (954) 236-5273.

Patient's Name (Please Print)

Date (mm/dd/yyyy)

Signature (if minor Parent or Guardian)

Patient's Legal Representative (if applicable)

Signature of Legal Representative

Date (mm/dd/yyyy)

FOR DENTAL OFFICE USE ONLY

We attempted to obtain write ACKNOWLEDGMENT of receipt of our Notice of Privacy Practices, but ACKNOWLEDGMENT could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the ACKNOWLEDGMENT.

An emergency situation prevented us from obtaining ACKNOWLEDGMENT

Other (please specify) _____