

**ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

**Stephanie Rose, DMD, Shruti Jadeja, DDS,
Denise Gates, DMD & Associates**

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires that health care providers give patients a copy of the office's Notice of Privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of the Notice.

You may refuse to sign this acknowledgement form.

By signing this form I confirm that I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient or Legally Authorized Representative

Date

Printed Name of Patient or Representative

Relationship to Patient

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
- Communication barriers prevented us from obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify): _____