Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

I ______________________________[full name], have received a copy of the Rebecca A. Marsh, DDS, APC Notice of Privacy Practices.

I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

Conduct, plan, and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtaining payment from third-party payers.

Conduct normal health care operations such as quality assessments and accreditation.

I understand that in the normal course of providing healthcare that my PHI may be transmitted via electronic messaging including, but not limited to, FAX, email and telephone messaging.

Print Name ______________________________

Signature ______________________________

Date ______________________________

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name ______________________________

Relationship to Patient ______________________________

For Program 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