Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(ADULT)

I have received a copy of the Notice of Privacy Practices of **Michael J Perona DDS.** I hereby authorize, as indicated by my signature below, **Michael J Perona DDS** to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

________________________________ ________________________________
Print Name Address

________________________________ ___________
Signature Date

Please check your preferred means of communication:

□ You may contact me at my home telephone number ____________________________
□ You may contact me on my mobile telephone number ___________________________
□ You may contact me on my work telephone number ____________________________
□ You may send me an email at: ____
□ Other ____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. ____ Date: Added / Removed: __________
2. ____ Date: Added / Removed: __________
3. ____ Date: Added / Removed: __________
4. ____ Date: Added / Removed: __________

* * *

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 prohibited obtaining the acknowledgement
□ An emergency situation prevented us from obtaining the acknowledgement
□ Other (Please Specify) ____
Staff Person Initials ___________