Endodontic Associates of Greater Washington

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HIPAA Acknowledgment

PATIENT INFORMATION

First Name		Last Name		Birth Date	

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

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

You have the right to revoke this consent at any time by giving us written notice.

1. _____
   Name Relationship to Patient

2. _____
   Name Relationship to Patient

3. _____
   Name Relationship to Patient

FORM COMPLETION

I acknowledgment that I have received a copy of this office's Notice of Privacy Practices.

Signature of Patient, Parent or Guardian		Date	

IF PATIENT IS A MINOR

Form signed by		Relationship to Patient	

FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign.
- ❑ An emergency situation prevented us from obtaining acknowledgment.
- ❑ Communication barriers prohibited obtaining the acknowledgment.
- ❑ Other (Please provide specific details).

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