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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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. If you wish to receive a copy of the Privacy Practices, please let our front desk know.

*****You May Refuse to Sign this Acknowledgment*****

I have reviewed a copy of this office's Notice of Privacy Practices and I understand that I may request a copy at any time.

Print name

Signature of Patient/Parent/Guardian

Date_____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself.

I authorize the following person(s) below to have access to information covered under the Privacy Practice regarding myself.

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

____ Communication barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other (Please Specify)