

# Highlands Dental

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**This form will be retained in your dental record.**

By my signature below, I \_\_\_\_\_, acknowledge that I have received a copy of the Notice of Privacy Practices for Highlands Dental.

I hereby designate the following individuals to receive communications from Highlands Dental that may include dental/medical information about me:

\_\_\_\_\_

\_\_\_\_\_  
Signature of patient (or personal representative)

\_\_\_\_\_  
Date

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

Personal Representative's Name; \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

I authorize Highlands Dental to leave voice mail messages concerning my health information (i.e. lab results, appointment instructions, etc.) at the following number:

Phone( ) \_\_\_\_\_ (Patient Initials) \_\_\_\_\_

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### For Office Use Only

I 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)

Employee Name \_\_\_\_\_ Date \_\_\_\_\_