Fishers Pediatric Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

_____ _____

{Patient Name / Your Child's First & Last Name} *{Today's Date}*

_____

{First & Last Name of ALL siblings}

Below is a list of ways our office may contact you. Please check all that apply. Checking a box will give permission to leave as thorough of a message as needed from our dental office.

- ☐ Home_____
- ☐ Work_____
- ☐ Cell_____
- ☐ Email_____
- ☐ All the Above

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize Fishers Pediatric Dentistry to release any information including diagnosis and the records regarding any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. In the event of my absence, the following individuals may bring my child/children to and from their appointments along with have access to medical and financial information**.**

1. _____ _____
   Name {Please Print}{Relationship to patient} *{Contact Number}*
2. _____ _____
   Name {Please Print}{Relationship to patient} *{Contact Number}*

I, _____, have been offered a copy of this office's Notice of

{PARENT/GUARDIAN Name}

Privacy Practices.

_____ _____

{Please Print PARENT/GUARDIAN Name} *{PARENT/GUARDIAN Signature}*

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)_____