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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. This also pertains to allowing your insurance carrier access to this same level of protected health information.

I wish to be contacted in the following manner (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Home Telephone _____ | <input type="checkbox"/> Written Communication |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address |
| <input type="checkbox"/> Leave message with callback number only | <input type="checkbox"/> O.K. to mail to my work/office |
| | <input type="checkbox"/> O.K. to fax to this number |
| <input type="checkbox"/> Work Telephone _____ | <input type="checkbox"/> O.K. to leave message concerning Pre-Medication |
| <input type="checkbox"/> O.K. to leave message with detailed information | |
| <input type="checkbox"/> Leave message with callback number only | <input type="checkbox"/> O.K. to provide my insurance carrier with necessary health information. |

Patient Signature

Date

Print Name

Birth date

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) _____