Harbor Bay Dental

Acknowledge For Receipt of Notice of Privacy Practices

This form is a receipt noting that you have received the Notice of Privacy Practices.

Name of Patient: _____
(Please Print)

Date of Birth: _____

Address: _____

_____

Date of Service: _____

I have received a copy of the Notice of Privacy Practices.

_____ _____
Signature Date of Receipt

If this form is being signed for a minor, an incompetent or otherwise incapacitated or deceased person, please fill in the following information.

Legally Authorized Representative's Name _____
(Please Print)

Patient is: _ Minor _ Incompetent or Incapacitated _ Deceased

Legal Authority: _ Legal Guardian _ Parent of Minor _ Other _____

_ Health Care Agent _____

_ Personal representative of deceased

For Office Use Only

- ○ Signature Declined (due to: _____
- ○ _____)
- ○ Signature Not Obtained Due to Patient Incapacitation
  Patient Signed Acknowledgement at Another UW HCC site _____

I personally delivered the Noticer of Privacy Practices to the patient listed above. A written acknowledgement of receipt by the patient was not obtained as noted above.

_____ _____
Signature of Office Staff Member Date

Name: _____
Please Print

Title: _____