



MOUNTAIN DENTAL

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES AND CONSENT**

I have received a copy of and have read Mountain Dental's *Notice of Privacy Practices*. I understand that this document provides an explanation of the ways in which my protected health information may be used or disclosed by Mountain Dental and of my rights with respect to my protected health information.

I am giving my consent to use and disclose of my protected health information to carry out treatment, payment activities, and health care operations (*without signature, we may decline to treat you*).

We may use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person acting on your behalf to pick up items that contain PHI. I am giving consent to disclose of my patient care records and protected health information to the following person(s), including those involved in my care or payment for that care:

Right to Revoke: This consent is effective until revoked by you. You may revoke this consent at any time by giving written notice of revocation to the office. Revocation of this consent will not affect any action we took in reliance on this authorization before we received your written notice of revocation.

Patient Name

Patient Signature

*Signature of Patient's Representative if
Patient is unable to sign*

Relationship

Date

To be completed by Mountain Dental personnel if form is not signed:

- Was the patient provided with a copy of the Notice of Privacy Practices?
 Yes No
- Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice, and explain why the patient was unable or unwilling to sign this form:
 Individual refused to sign
 Communications barriers prohibited obtaining the acknowledgement
 An emergency situation prevented us from obtaining acknowledgement
 Other (please specify): _____
