



Acknowledgement of receipt of notice of privacy practices
and authorization to share my protected health information

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

(Please Print Name)

(Signature)

(Date)

In addition, as of the date indicated above, I hereby request and grant Chesney Dentistry permission
to share my protected health information with the person(s) or organization(s) listed below.

- Spouse: _____ phone number: _____
- Parent or child: _____ phone number: _____
- Other: _____ phone number: _____

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)