## Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

Patient name ______________________________________________ Birthdate: / /

I have read and been offered a hard copy or an electronic copy of the HIPAA Notice of Privacy Practices for Hymas Family Dental. I understand that I am entitled to receive a hard copy of the Notice if I ask for it, even if I have already agreed to receive only an electronic copy.

***X*** ____________________________________________________________________ Date signed: __________

*Signature of patient or responsible person*

Relationship to patient – Please Circle One **SELF** **PARENT** **GUARDIAN** **LEGAL REPRESENTATIVE**

***If applicable:***

Patient's Guardian or Representative's name ____________________________ Phone___________________

Representative's relationship to patient: ____________________________

Representative's address:

___________________________________________________________________________

## Permission To Discuss Treatment Or Billing Information

I give permission to discuss my treatment and or billing information with:

Name____________________________ Relationship to patient ____________________________

Name____________________________ Relationship to patient ____________________________

Name____________________________ Relationship to patient ____________________________

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