Caceci Family Dentistry

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ACKNOWLEDGEMENT OF RECEIPT AND ACCEPTANCE OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I was given the opportunity to review this office's Notice of Privacy Practices (HIPAA), and that I have the right to ask for a copy of them to be provided to me if I so choose. I further acknowledge that a copy of the current notice will be posted in the reception area and I may request a copy of the amended Notice of Privacy Practices at each appointment. Due to HIPAA laws, the office is unable to share my medical/dental information with anyone unless I authorize them to do so.

I authorize Caceci Family Dentistry to discuss my medical/dental information with the person(s) below:

Name: _____ Relationship to patient: _____ Phone #: _____

Name: _____ Relationship to patient: _____ Phone #: _____

Patient Name: _____

Patient (or guardian) Signature: _____ Date: _____

Guardian's Name (if applicable): _____