RUSSO
FAMILY DENTAL
321 Washington Street
Gloucester, Massachusetts 01930
Phone: 978-281-1337

Acknowledgement of Receipt of Notice of Privacy Practices

HIPAA Authorization

I hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information,
- My privacy rights with regard to my protected health information,
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any questions or complaints, I may contact:

Russo Family Dental
321 Washington St.
Gloucester, MA 01930
Attn: Compliance Officer

I may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures.

Signature ____ Date ____/____/_______

Name ____

Relationship to Patient ____

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of 's receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

- ○ Patient refused to sign (date of refusal)
- ○ Communication barriers prohibited obtaining an acknowledgment
- ○ An emergency situation prevented us from obtaining an acknowledgment
- ○ Other ____

Attempt was made by: ____________________________________ Date ____/____/_______