HIPAA Acknowledgment of Receipt of Notice of Privacy Practices

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Patient Name: _____

Date of Birth: _____

Parent/Guardian Name (if patient is a minor): _____

Our Commitment to Your Privacy

At Dhaduk Pediatric Dentistry, we are dedicated to protecting the privacy of your child's health information. Our Notice of Privacy Practices describes how we may use and disclose health information about your child, as well as your rights regarding this information.

The Notice of Privacy Practices is available:

☐ In our office

☐ On our website

☐ Upon request

Acknowledgment

By signing below, I acknowledge that I have received a copy of Dhaduk Pediatric Dentistry's Notice of Privacy Practices.

I understand that the Notice of Privacy Practices provides detailed information about how my child's health information may be used and disclosed, and how I can access this information.

Signature of Parent/Guardian or Patient (if 18 or older):
_____

Date: _____

For Office Use Only

☐ Patient/Parent declined to sign acknowledgment.

☐ Good faith effort was made to obtain acknowledgment but was unsuccessful.

Comments: _____