HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, ____________________________, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

________________________________ _____________ __________________________

{Signature of Patient and/or Guardian} {Date} {Relationship to Patient}

I, __________________________, acknowledge and allow **Prime Dental Group - Jin T. Lee, D.D.S.** to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] No information is to be released to anyone.

EMAIL COMMUNICATION AND TEXT/VOICE MESSAGES

I agree that **Prime Dental Group** may communicate with me electronically at the email address below, including text messages to my cell phone number below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages and that I am responsible for providing Prime Dental Group any updates to my email address and cell phone number.

If unable to reach me:

[ ] You may leave a detailed message on voice mail/text/email (PLEASE PRINT CLEARLY)

Cell Number: _________________________ **Email**: ____

[ ] Please leave me a message asking for a return call

This **Release of Information** will remain in effect until terminated by me in writing.

Signed: ____Date: ____/____/_______

Witness: ____ Date: ____/____/_______