HIPAA WRITTEN ACKNOWLEDGEMENT FORM

RIVERBEND DENTAL CENTER

Acknowledgement of Receipt of Health Information Privacy Practices Notice

I, ___________________________________ (Patient Print Name), understand that as part of my health care, Riverbend Dental Center originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment, and any plans for future care, and/or treatment. I acknowledge that I have been provided with and understand that Riverbend Dental Center's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

_____ I have the right to review Riverbend Dental Center's Notice of Privacy Practices prior to signing this acknowledgement;

_____ That Riverbend Dental Center reserves the right to change their Notice of Privacy Practices and prior to implementation of this, Riverbend Dental Center will mail a copy of any revised notice to the address I have provided if requested.

______________________________________ Signature of Patient or Legal Representative

______________________________________ Printed Name of Patient or Legal Representative

______________________________________ Date Notice Signed

FOR OFFICE USE ONLY

_____ **Patient Refused to Sign**

_____ **Communication Barrier Prohibited Obtaining Signature**

_____ **Other (Please Specify Below)**

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