Black Hills Area Dental

Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print Name_____

Signature: X_____

Date:_____

Children's Names (if under 18)_____

DISCLOSURE OF HEALTH INFORMATION

Patient Name_____Patient SSN_____

Patient DOB_____

If you would like us, at **Black Hills Area Dental**, to answer all dental/medical questions freely, especially where our response requires disclosure of your protected health information, please complete form.

May we, at **Black Hills Area Dental**, speak with someone else regarding your dental/medical care?

Yes ◯ **No** ◯

Name of person_____Relationship_____

Phone_____Specific Information_____

Name of person_____Relationship_____

Phone_____Specific Information_____

Purpose: I am requesting this designation so that the names person(s) can handle all questions and issues related to my eligibility for coverage, plan benefits, payment of claims and preauthorizations of treatment as well as the financial aspect of my dental treatment. This authorization form allows **Black Hills Area Dental** to disclose and discuss past, present and future information with the person(s) designated above until I revoke this designation in writing.

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

◯ Individual refused to sign
◯ Communication barriers prohibited obtaining the acknowledgement
◯ An emergency situation prevented us from obtaining acknowledgement
◯ Other (please specify)