



## 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: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Children's Names (If under 18 years of age) \_\_\_\_\_

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### DISCLOSURE OF HEALTH INFORMATION

May we, at Black Hills Area Dental, speak with someone else regarding your dental or medical care? Yes, please provide information below. No

Name of person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Disclosure Allowed: \_\_\_\_\_

Name of person: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Disclosure Allowed: \_\_\_\_\_

Purpose: I am requesting the designation so that the name(s) can handle all questions and issue related to my eligibility for coverage, plan benefits, payment of claims and preauthorization of treatment as well as the financial Aspect of my dental treatment. This authorization forms 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) \_\_\_\_\_