

Spring Street Dental
1410 Spring Street #A, Jeffersonville, IN 47130
(812) 285-1006 Fax: (812) 285-1132

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of Spring Street Dental's Notice of Privacy Practices, which has an effective date of 09/13/2013 and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

Signature of Patient or Patient's Representative

Date

Print Name

Relationship to Patient (If not signed by the Patient)

------(FOR OFFICE USE ONLY)-----

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

