Abbey Horwitz D.D.S. *the art of dentistry*

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Receipt of Notice of Privacy Practices
"You May Refuse to Sign This Acknowledgment"

I, _____, have received and read a copy of this practices Notice of Privacy Practices and hereby give my consent to use and disclose my protected health information to provide treatment, request payment, and for daily health care.

This office is HIPAA Compliant. In order to protect your privacy to the best of our ability, please list three people, if any, that you allow us to discuss your information with.

1. _____ 2. _____ 3. _____

_____
Patient Name, if minor (please print)

_____
Patient/Parent Signature

_____
Date

_____
Witness

Practice Purposes Only:
Our practice attempted to obtain written consent for Notice of Privacy Practices. Receipt could not be obtained for the following reason:

_____ An emergency occurred and prevented us from obtaining
_____ Patient refused to sign notice
_____ Other (please specify)
_____

_____