Dr. Joseph Gul, DMD

NOTICE OF PRIVACY PRACTICES AND DISCLOSURE ALLOWANCES

Acknowledgement of Receipt

Date:_____

I acknowledge that I was provided with a copy of the Notice of Privacy Practices.

_____ _____

Patient Name (Please Print) Patient Signature

If completed by a patient's personal representative or parent, please print and sign your name in the space below.

_____ _____

Personal Representative Name (Please Print) Personal Representative's Signature

_____

Relationship

I authorize the disclosure of my health and financial information to the following family members or personal representatives:

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Patient or Representative's Name (Please Print) Patient or Representative's Signature

OFFICE USE ONLY

☐ Individual Refused to Sign ☐ Communications Barriers prohibited obtaining acknowledgement

☐ Other (specify below) ☐ Emergency Situation prevented obtaining the acknowledgement

_____