# HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Farrokh Bashiri, DDS

**Acknowledgement of receipt of Information Practices Notice (code 164.520(a))**

I.___________________________(Patient's Name) understand that as part of my healthcare, Farrokh Bashiri, DDS originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that **Farrokh Bashiri, DDS** Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

• I have the right to review Farrokh Bashiri DDS' Notice of Privacy Practices prior to signing this acknowledgement;
• That Farrokh Bashiri, DDS reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided Is requested.

**Signature of Individual or Legal Representative**
**Witness_________________________________**
**Printed Name of individual or Legal Representative Witness _________ Date _____**

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:
__ Individual refused to sign
__ Communication barrier prohibit obtaining the acknowledgement
__An emergency situation prevented us from obtaining acknowledgement
__Others (Please specify)

________________________________________________________________________________

Farrokh Bashiri, DDS