Acknowledgement of Receipt of Notice of Privacy Practices

Please list the names, (first and last) of all minor children covered under this Notice.

______________________________ ___________
Printed Name *Date of Birth*

______________________________ ___________
Printed Name *Date of Birth*

______________________________ ___________
Printed Name *Date of Birth*

______________________________ ___________
Printed Name *Date of Birth*

I have been given a copy of the Dentistry for Kids / Hunt Valley Orthodontics *Notice of Privacy Practices* (“*Notice*”), which describes how the Practice uses and shares health information regarding the above-named minor children. I understand that the Practice has the right to change the *Notice* at any time. I may obtain a current copy by contacting the Practice Privacy Officer.

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

______________________________________ ____________
Signature of Patient/Parent or Personal Representative *Date*

____
Print Name

____
Personal Representative’s Title (e.g., Guardian, Health Care Power of Attorney)

I specifically request that the following individuals be granted access to medical information about myself (or if a minor, my child) without restriction:

Name: ____________________________ Relationship: ______________________

Name: ____________________________ Relationship: ______________________

For Facility Use Only: Complete this section if you are unable to obtain a signature.

If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

____

____

Completed by:

______________________________ ___________
Signature of Practice Representative *Date*

____
Print Name and Title