

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

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Paul Polyviou, DDS, P.C. & Associates

**PLEASE SIGN THIS FORM BELOW UNDER THE HEADING “CONSENT” TO CONSENT TO OUR DISCLOSURES OF YOUR INFORMATION THAT WE DEEM NECESSARY IN ORDER TO PROVIDE YOU WITH PROPER TREATMENT.**

**PART ONE: Acknowledgement of Receipt of Privacy Notice**

I, \_\_\_\_\_, acknowledge that I have received a Notice of Privacy Practices from the above named practice.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If a personal representative signs this authorization on behalf of the individual, please complete the following.**

Personal Representative’s Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

**PART TWO: Good Faith Effort to Obtain Acknowledgement of Receipt**

Patient Refused to sign:

Describe your good faith effort to obtain the individual’s signature on this form:

\_\_\_\_\_

\_\_\_\_\_

Describe the reason why the individual would not sign the form

\_\_\_\_\_

\_\_\_\_\_

**PATIENT CONSENT**

I attest that the above information is correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_