Westfield Pediatric Dental Group

Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgement

I, ___________________________, have received a copy of this office's Notice of Privacy Practices.

* I acknowledge that Westfield Pediatric Dental Group will follow all rules, regulations and guidelines concerning HIPPA, and I give Westfield Pediatric Dental Group consent to contact me via email, cell phone, home phone, and any other contact that I have provided to the practice with detailed information regarding my child's dental visits.
*I also authorize Westfield Pediatric Dental Group to share information with referring doctors such as x rays, progress notes and any pertinent information the referring doctor may require in order to properly evaluate the patient.

Print Name ____

Signature ______________________ Date ____________________

Patient Name ____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ **Individual refused to sign**
___ **Communications barriers prohibited obtaining acknowledgement**
___ **An emergency situation prevented us from obtaining acknowledgement**
___ **Other (please specify)**

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