

CRAWFORD ENDODONTICS

- You May Refuse to Sign This Acknowledgement*

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

Print Name: _____

Signature: _____

Date: _____

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 the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

HEALTH INFORMATION PRIVACY POLICIES & PROCEDURES

We implement the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"), as amended (September 23, 2013), and state law that provides greater protection of rights to patients. We may use and disclose your health information for treatment, payment, healthcare operations, and/or when sending you a 6-mo. Check-up reminder post card in the mail.

I HAVE READ AND UNDERSTAND AND AGREE TO ALL OF THE ABOVE INFORMATION:

X _____ DATE _____

HIPAA PRIVACY ACT-----KEEPING YOUR INFORMATION PRIVATE!