



Garret Family Dental Care
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ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I hereby acknowledge that I have read this office's Notice of Privacy Practices.

X _____
 Signature of Patient or Responsible Party Date

 Print name of Patient or Responsible Party

I hereby give permission for Garrett Family Dental Care to disclose, to the following family members or friends, my protected health information that is directly relevant to such person's involvement with my care or payment related to my care. Garrett Family Dental Care may also use or disclose this information as necessary to notify the following individuals of my general condition, location or death.

PERMISSION EXTENDED TO THE FOLLOWING INDIVIDUAL(S):

NAME _____	_____	_____
	First	Last
NAME _____	_____	_____
	First	Last
NAME _____	_____	_____
	First	Last
NAME _____	_____	_____
	First	Last

Check here if you do **NOT** want your health information accessible to any individuals. *(This does NOT include any medical/dental offices that may have direct involvement with your care.)*

Office Use Only

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

- Individual refused to sign.
- Communication barriers prohibited obtaining the acknowledgement.
- An emergency situation prevented us from obtaining acknowledgement.
- Other (Please Specify) _____

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