

Ramsey Dental Group
Lady-Jean M. Ramsey, DMD, LLC
Brian V. Gilmore, DDS
Michael DuVall, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please Note: It is your right to refuse to sign this Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices. I understand that if I have questions or complaints, I may contact the Facility Privacy Official.

I understand that if I request communication with this office through e-mail, that it is not a secure method of electronic communication and therefore may possibly be intercepted by someone outside of this office.

Patient Signature and Date

OR

Signature of Personal Representative and Date

Authority of Personal Representative to Sign for Patient (circle one):

Parent Guardian Power of Attorney Other: _____

Disclosure of Protected health Information to Patient's Family Members or Others

Under the Health Insurance Portability and Accountability Act of 1996, as amended, patients have the right to agree, restrict or object to providing PHI to family members or other persons identified as involved in the patient's care or payment for the patient's healthcare. To comply with the regulations, as outlined in our facility policies, documentation of the patient's wishes must be present in the dental record.

I am granting permission for Ramsey Dental Group to release PHI concerning myself to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ **Date:** _____

For Office Use Only

Ramsey Dental Group made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of receipt of the Notice of Privacy:

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

Staff Member Signature:

Date: