Dr. John Hutchison D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Communication (HIPAA)

You may refuse to sign this acknowledgment & authorization. In refusing we will **not** be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Dr. John Hutchison D.D.S.. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT/ RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.

_____ _____

Please **print** your name Please **sign** your name

_____ _____

Legal Representative Description of Authority

By Law, without your authorization, our office cannot communicate with:

1. Your Spouse/Significant other
2. Your adult Children or Caregivers
3. Your parents (if you are age 18 or over)

Our office may need to communicate with your family or caregivers in the following circumstances:

1. Making appointments
2. Confirming appointments
3. Discussing treatment needed or performed
4. Account or Financial Information

Please indicate below the names of people who we may communicate with regarding your appointment, medical/dental or account information:

☐ My Spouse _____

☐ My Adult Children _____

☐ My Caregivers _____

☐ Other _____

☐ I do not wish to allow any of my information to be shared with anyone including my spouse, or any other family member and or guardian.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgment but did not because:

It was emergency treatment _____

I could not communicate with the patient_____

The patient refused to sign_____

The patient was unable to sign because_____

Other (please describe)

_____

Signature of Privacy Officer