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

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 IREQUEST TREATMENT/ RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE. Please print your name	Date	2:	insurance cianns.
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	The Hute MY	undersigned acknowledges receipt chison D.D.S A copy of this signed SIGNATURE WILL ALSO SER	I, dated document shall be as effective as the original. VE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST
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☐ 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)	<u>P</u>		
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