{Bruce A. Boretsky, D.M.D., LLC}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

****You May Refuse to Sign This Acknowledgement****

I, _____, will receive a copy of this office's Notice of Privacy Practices upon request
(*Please print patient's name*.)

Please list ALL those you give permission to access your chart information. Such person may call on your behalf to ask questions regarding treatment and appointments, etc.
Please indicate the relationship to patient and whether they are to have full (appointments and treatment info) or partial (appointments only) access to patient's chart information.

Name:	Relationship:	Access:
_____	_____	full or partial
_____	_____	full or partial
_____	_____	full or partial

Any limitations regarding disclosure are listed below. This authorization remains in effect until revoked.

_____
(***Print*** *parent's or guardian's name if applicable*.)

_____ Date: _____
(***Signature*** *of patient, parent or guardian please*.)

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)