Pediatric Dentistry

Acknowledgement of Privacy Practice

You May Refuse to Sign This Acknowledgement

I, _____ (PATIENT Name), acknowledge common privacy practices regarding patient information. A written policy is available for review upon request via mail, fax or email.

Signature: _____

Date:_____

FOR OFFICE USE ONLY

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

_____ Individual Rrefused to sign

_____ Communications barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify) _____

Date: _____ Initials: _____

290 Baker Avenue | Concord, MA 01742 | 978.369.7771
219 Boston Post Road West | Marlboro, MA 01752 | 508.481.8161