Evergreen Dental Group, PC

Acknowledgment of Receipt of Notice of Privacy Practices

We may release relevant health information and/or billing information associated with your treatment to family or Power of Attorney upon their request if we can reasonably conclude, based on professional judgment, that the patient does not object. If you do not want information to be released to spouse, family or Power of Attorney please inform Evergreen Dental Group personnel. This signed authorization form allowing release of information remains valid unless the patient requests a change.

If I am unable to be reached, I give my permission to have messages regarding my appointment time, changes of, or scheduling information left on my answering machine/voice mail or with a family member or person answering the phone.

** You May Refuse to Sign This Acknowledgement **

I, _____, have read a copy of this office's Notice of Privacy Practices.

_____
(Signature)

_____
(Date)

FOR OFFICE USE ONLY

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

____ Individual refused to sign
____ Communications barriers prohibited obtaining acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (Please Specify)

_____
_____
_____