

# Meyer and Johns Dental, LLC

---

## Acknowledgement of Receipt of Notice of Privacy Practices

---

My signature on this form acknowledges that I have received a copy of the HIPAA Notice of Privacy Practices document. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Meyer and Johns Dental, LLC and of my rights with my health information. I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient's Representative  
If patient is unable to sign

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

1. Do you allow us to contact you by phone calls, text messages and email regarding appointments or any other matter that may arise?  Yes  NO

2. Can we leave a message for you on the numbers you have provided us?  Yes  No

### Sharing Protected Health Information with Family and Friends

Please list all family members you give us consent to share your health information with.

Name

Relationship

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

---

### TO BE COMPLETED BY DENTAL OFFICE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices?

Yes  No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was not able or unwilling to sign this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_