

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Prosthodontics of Texas, P.C.
5301-A Davis Lane, Suite 101
Austin, TX 78749

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of [Prosthodontics of Texas, P.C.]'s *HIPAA Notice of Privacy Practices*.

I understand that [Prosthodontics of Texas, P.C.]'s *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of [Prosthodontics of Texas, P.C.]'s revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about [Prosthodontics of Texas, P.C.]'s *HIPAA Notice of Privacy Practices*, I may contact [Stewart Pharr. 512-960-4225. 5301-A Davis Lane, Suite 101, Austin, TX 78749].

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that [Prosthodontics of Texas, P.C.] will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding [Prosthodontics of Texas, P.C.]'s privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask [Stewart Pharr. 512-960-4225. 5301-A Davis Lane, Suite 101, Austin, TX 78749], noted above, for assistance.

Patient Signature

Date

Signature of Personal Representative

Print Name of Personal Representative

Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

[Prosthodontics of Texas, P.C.] made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, [Prosthodontics of Texas, P.C.] was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date Received	By	Patient ID
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