Mount Vernon Dental Group

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Acknowledgement of Receipt of Notice of Privacy Practices

Notice of Privacy Practices Acknowledgment of Receipt:

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I acknowledge that I have received or have been given the opportunity to receive a copy of Mount Vernon Dental Group's Notice of Privacy Practices. I also understand that Mount Vernon Dental Group has the right to change its Notice of Privacy Practices and that I may contact any office to obtain a current copy of the
Notices of Privacy Practices.

**** You may refuse to sign this acknowledgement****

I have received a copy of this office's Notice of Privacy Practices. * ◯ Yes ◯ No

Name: *

Signature _____ **Date** _____

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
☐ Communication barriers prohibited us from obtaining acknowledgement
☐ An emergency situation prevented us from obtainng acknowledgement
☐ Other (Please Specify)

Response Date: _____