CORNERSTONE
DENTAL ARTS

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE PROTECTED HEALTH INFORMATION

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

In addition, as of the date indicated above, I hereby request and grant Cornerstone Dental Associates, PLLC permission to share my protected health information with the person(s) or organization(s) listed below.

☐ Spouse: _____ Phone number: _____

☐ Parent or child: _____ Phone number: _____

☐ Other: _____ Phone number: _____

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