Divine Smiles DENTISTRY

8001 Wisconsin Ave, Suite 103
Bethesda, MD 20814
Office: (301) 312-8210
Fax: (301) 312-8572

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

_____
Patient Name (Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

_____
Authority of Personal Representative

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

For Office Use Only

_____ An emergency prevented us from obtaining acknowledgement.

_____ A communication barrier prevented us from obtaining acknowledgment.

_____ The individual was unwilling to sign.

_____ Other:

_____
Staff Member Signature Date