

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement but, in refusing we  
will not be allowed to process your Insurance Claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for  
Dr. Alan Reisman, DDS. A copy of this signed, dated Acknowledgement shall be as  
effective as the original.

\_\_\_\_\_  
Please print your name

\_\_\_\_\_  
Please sign your name

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR DENTAL INFORMATION:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

-----  
I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY DENTAL APPOINTMENTS VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation email address: \_\_\_\_\_

I AUTHORIZE INFORMATION ABOUT MY DENTAL HEALTH BE CONVEYED VIA:

- ☐ Message on Cell Phone
- ☐ Message on Home Phone
- ☐ Message on Work Phone
- ☐ Text Message
- ☐ Email Message email address: \_\_\_\_\_
- ☐ In-Person
- ☐ **Any of the above**

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS or NEW DENTAL INFO via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email email address: \_\_\_\_\_
- ☐ **Any of the above**

-----  
**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement but did not because:

It was emergency treatment \_\_\_\_\_  
I could not communicate with the patient \_\_\_\_\_  
The patient refused to sign \_\_\_\_\_  
The patient was unable to sign because \_\_\_\_\_  
Other (please describe) \_\_\_\_\_

\_\_\_\_\_  
Signature of Privacy Officer