ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

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

___I have read and declined receiving a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**

Authority of Patient Representative to sign for Patient (check one):

___Parent ___Guardian ___Power of Attorney ___Other:_____

DESIGNATION OF RELEASE OF HEALTH INFORMATION

The office of Tessa L. Buchanan, DDS adheres to a policy of not releasing protected health information to individuals other than the patient or patient representative. By indicating below, you can designate others to receive your health information. Please choose and mark one of the options below:

___Option A: I choose to have my health information released only to me.

___Option B: I authorize the office of Tessa L. Buchanan, DDS to release protected healthcare information about me to the following individual:

Names(s) _____Relationship(s) _____

Patient or Patient Representative Signature **Date**

Patient or Patient Representative Signature **Date**

Patient or Patient Representative Signature **Date**

Patient or Patient Representative Signature **Date**

Patient or Patient Representative Signature **Date**

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