West Georgia Family Dentistry
8590 Bowden Street
Douglasville, GA 30134

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have viewed and had an opportunity to receive a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature) (Date)

See laminated copy of the HIPAA Privacy Notice for your view & acceptance displayed on the wall. Please ask for a printed copy of the HIPAA Privacy Notice if you wish to retain for your records.

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a Restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check ALL that apply):

_____HOME TELEPHONE_____

_____WORK TELEPHONE_____

_____CELL PHONE_____

_____FAX _____

_____EMAIL_____

OTHER_____

I allow you to discuss my clinical information, or answer questions in regards to my patient account, with the following person(s).

NAME_____RELATIONSHIP_____

_____ _____

_____ _____

_____None (initial here if applicable) EXPIRES ON_____NO EXP_____

_____	_____	_____
Print Name	Sign (patient or guardian)	Today's Date