BEDFORD
ORAL SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

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

I give permission for Dr. Baldassarre's office to e-mail treatment information to my healthcare providers. The e-mail communications are sent SECURE/ENCRYPTED.

If you would like us to share your treatment information with any other person, please list their name(s) (e.g. spouse, parent) _____

Please Print Name/Signature: _____

Date: _____

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

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

- Saved in 000 MAB PRINTABLE FORMS000