Wendy K. Humphrey, DMD, PLLC
Kentucky Dentistry for Kids

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this Acknowledgement

The Health Insurance Portability and Accountability Act (HIPPA), requires us to give you notice of our privacy practices and to acknowledge your receipt of this notice.

The Notice of Privacy Practices explains how your health information may be used and or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities. You can view the Privacy practices in our office or we can mail/email you a copy.

I have been provided with a copy of the Notice of Privacy Practices in electronic or paper format.

_____ _____
Print Name of Parent/Guardian Signature of Parent/Guardian

_____
Date

_____ _____
Patient Name Patient Name

_____ _____
Patient Name Patient Name

_____ _____
Patient Name Patient Name

Please list names of others with whom you would like to give permission to share your child/children's healthcare information (these may include family members or other individuals):

_____ _____

_____ _____

May we leave detailed dental information on your home voice mail? ____Yes ____No
May we leave detailed dental information on your cell phone? ____Yes ____No
May we leave detailed dental information on you work voice mail? ____Yes ____No
May we mail/fax appointment excuses to your child/children's school? ____Yes ____No

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:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other: _____

_____