
Greencastle Pediatric Dentistry, P.C.
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.

(Please Print Name)

(Child's Name)

(Signature)

(Date)

Contact Information for Protected Health Information

I, _____, (date of birth: _____) request that the following information be used for the disclosure of my (or dependent) **Protected Health Information**. This information will include your name, diagnosis, treatment, and dates of service.

? You may disclose information to those individuals listed below. (Please list name, phone number, and relationship to patient)

Name	Phone Number	Relationship to Patient

? You may leave Protected Health Information on my answering machine.

(Date)

(Patient's Name)

(Patient's Date of Birth)

(Guardian's Printed Name)

(Guardian's Signature)
