

**TRUE NORTH DENTAL GROUP**

*Your Privacy Is Important to Us*

**Acknowledgement of Receipt of Notice of Privacy Policies**

I have received a copy of the Notice of Privacy Practices of True North Dental Group. I hereby authorize, as indicated by my signature below, True North Dental Group to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please check your preferred means of communication:**

- You may contact me at my home telephone number \_\_\_\_\_
- You may contact me on my mobile telephone number \_\_\_\_\_
- You may contact me on my work telephone number \_\_\_\_\_
- You may send me an unencrypted email/text message at: \_\_\_\_\_
- Other \_\_\_\_\_

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

- 1. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
- 2. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
- 3. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_
- 4. \_\_\_\_\_ Date Added / Removed: \_\_\_\_\_

\* \* \*

**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 the acknowledgement
- Other (Please Specify) \_\_\_\_\_

Staff Person Initials \_\_\_\_\_