

ACKNOWLEDGEMENT OF RECEIPT OR REVIEW OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Address: _____

Facility Name: **Precision Dental of Windsor**

I have been given or have read a copy of Precision Dental of Windsor's *Notice of Privacy Practices* ("Notice"), which describes how my health information is used and shared. I understand that Precision Dental of Windsor has the right to change this *Notice* at any time. I may obtain a current copy by contacting or visiting Precision Dental of Windsor.

My signature below acknowledges that I have read or been provided with a copy of the *Notice of Privacy Practices*:

Signature of Patient or Personal Representative Date

Print Name

Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)



For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement*:

Completed by:

Signature of Facility Representative Date

Print Name

File original in patient's Business Office Records

