**ACKNOWLEDGEMENT OF PRIVACY PRACTICES**

Patient First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday [mm/dd/yyyy]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that I have received a copy of Prime Pediatric Dentistry’s Notice of Privacy Policy.**

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give full permission for the below listed, to have complete access to patient listed above. This includes, but is not limited to: chart details, x-rays, and dental restoration needed. I also give full authority to make any decisions necessary for any treatment planned in relation to the patient’s dental needs from Prime Pediatric Dentistry.

Name/Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Staff Will Complete This Section If Patient’s Signature Not Obtained.**

Our office made a good faith effort to obtain a Written Acknowledgement or Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reasons.

\_\_ Parent/Patient/Guardian refused to sign.

\_\_ Emergency situation kept us from obtaining signature.

\_\_ Language barrier kept us from obtaining signature

\_\_ Other

Signature of Company Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_