

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Kids Rock! Pediatric Dentistry

700 E. Ogden Ave., Suite 110

Westmont, IL 60559

Acknowledgement

On behalf of, (Name of Patient/s) _____ I hereby acknowledge that I have received and reviewed a copy of Kids Rock! Pediatric Dentistry's *HIPAA Notice of Privacy Practices*.

I understand that Kids Rock! Pediatric Dentistry's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Kids Rock! Pediatric Dentistry's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about Kids Rock! Pediatric Dentistry's *HIPAA Notice of Privacy Practices*, I may contact 630-986-1234.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Kids Rock! Pediatric Dentistry will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Kids Rock! Pediatric Dentistry's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask the front desk at 630-986-1234, noted above, for assistance.

Parent or Legal Guardian Signature

Date

Print Name of Parent or Legal Guardian

Relationship to Patient

FOR OFFICE USE ONLY

Kids Rock! Pediatric Dentistry made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Kids Rock! Pediatric Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgement on _____, 20_____.
- Communications barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____

Date Received	By	Patient ID