Albany Family Dentistry, P.A.

Acknowledgment of receipt of notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in Albany Family Dentistry, P.A.'s Notice of Privacy Practices. Albany Family Dentistry, P.A. is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

By signing below, you are acknowledging that you have seen and/or received at your request a copy of Albany Family Dentistry, P.A.'s Notice of Privacy Practices.

Patient name:_____

Patient Date of Birth:_____

Patient Representative:_____

If signed by Patient Representative, state authority to act on behalf of patient:

Signature:_____ Date:_____

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Albany Family Dentistry, P.A. use only

I,_____attempted to obtain the patient's acknowledgment of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained**:**_____

Signiture:_____Date:_____