



HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Regulations require that we make a “good faith” effort to provide you with a copy of our HIPAA Privacy Practices Notice. However, you are not required to accept the Notice, only to acknowledge that we have made you aware of our HIPAA Notice of Privacy Practices.

I, _____, have received a copy of, or acknowledge the
[Patient Name]
Bay Area Endodontics HIPAA Notice of Privacy Practices.

Patient Signature

Date

I give my permission to release my medical information to: (optional)

Name

Relationship

Name

Relationship

FOR OFFICE USE ONLY

WHEN EFFORTS TO OBTAIN PATIENT ACKNOWLEDGEMENT WERE UNSUCCESSFUL:

NAME OF PATIENT: _____

I provided the above-named patient with the HIPAA Notice of Privacy Practices for
Bay Area Endodontics on _____.
Date

Describe how Notice was offered or provided:

Offered copy and patient refused to accept delivery

Offered copy and patient accepted delivery but refused to sign.

Other [describe]: _____

Employee Signature

Date