Kari Mann DENTAL STUDIO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered a copy of the office's Notice of Privacy Practices. Kari Mann Dental Studio provides this form to comply with the HIPAA requirements. Please review the Notice of Privacy Practices before signing this document.

By signing this form, you acknowledge that we may use and disclose your protected health information for treatment, payment, and healthcare operations. You have the right to request that we restrict how your protected health information is used or disclosed for treatment, payment, and healthcare operations.

Communication: Our office will communicate with you regarding your care and appointments via phone calls, text, and email utilizing the numbers and email address provided on your intake forms. By signing this form you are giving us permission to communicate via text message, email, phone call, and to leave voicemails. If you wish to opt out of any of these forms of communication, please indicate below.

_____

I give permission for you to speak with these individuals about my care:
(Note: Please notify us if you wish to make a change in the future.)

Name	Relationship	Phone Number

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____ _____
Print Name of Patient or Legally Authorized Representative Legal Relationship to Patient