ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

THE UNDERSIGNED ACKNOWLEDGES RECEIPT OF A COPY OF THE CURRENTLY EFFECTIVE NOTICE OF PRIVACY PRACTICES FOR PAUL D. HEIDRICH, JR., D.M.D. THIS _____ DAY OF _____ 20___. A COPY OF THIS SIGNED, DATED, ACKNOWLEDGEMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

_____PLEASE PRINT YOUR NAME

_____PLEASE SIGN YOUR NAME

IF YOU ARE THE LEGAL REPRESENTATIVE OF THE PATIENT, PLEASE PRINT THE PATIENTS' NAME AND YOUR RELATIONSHIP TO PATIENT.

_____

OFFICE USE ONLY

AS PRIVACY OFFICER, I ATTEMPTED TO OBTAIN THE PATIENT'S (OR REPRESENTATIVE'S) SIGNATURE ON THIS ACKNOWLEDGEMENT BUT DID NOT BECAUSE:

IT WAS EMERGENCY TREATMENT _____

I COULD NOT COMMUNICATE WITH THE PATIENT_____

THE PATIENT REFUSED TO SIGN _____

THE PATIENT WAS UNABLE TO SIGN _____

SIGNATURE OF PRIVACY OFFICER_____

VIEW HIPPA PRIVACY ACT @ http://www.hhs.gov/ocr/hipaa/finalreg.html