

Drs. Bradbury and Amato, P.C.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

***You May Refuse to Sign This Acknowledgement ***

I give **Drs. Bradbury & Amato, P.C.** consent to release private health information for the benefit of my continued quality healthcare. Healthcare information may be released to my primary care physician, referring specialist, insurance company or another dentist involved in my care. For this purpose private health information is defined as personal information, examination findings and/or treatment either proposed, underway or completed.

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I also give **Drs. Bradbury & Amato, P.C.** permission to leave appointment reminders and/or other pertinent messages on my answering machine, e-mail or at my place of employment, per my request, and/or to contact me by post card or letter.

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I understand that any information that has already been disclosed was not protected by this document. I also understand that I may revoke this authorization, in writing, at any time.

Please Print Patient Name

Signature of Patient/Guardian

Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ____ Individual refused to sign
- ____ Communication barriers prohibited obtaining the acknowledgement
- ____ An emergency situation prevented us from obtaining acknowledgement
- ____ Other (please specify)