



ACKNOWLEDGEMENT OF OFFICE POLICY REGARDING PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

I, [REDACTED] have received and/or been
Patient/Parent or Guardian Signature

offered a copy of Rocky Point Family Dentistry's notice of privacy practices. I authorize Rocky Point Family Dentistry to release my dental and billing information to the following individual(s):

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____

Print Patient Name: _____

Print Parent/Guardian's Name (if patient is a minor): _____

Date _____

****YOU MAY REFUSE TO SIGN THIS DOCUMENT****

Form not signed due to:

- ___ Patient refusal
- ___ Communication barrier prohibiting acknowledgement
- ___ Emergency situation preventing acknowledgement
- ___ Other (Please specify)

Staff Member _____ Date _____