ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
HIPAA/HB-300

I, _____, hereby acknowledge that I have received a copy of this practice Forever Smiles P.A.'s Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA and HB-300 privacy rules give the individual the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____
- ☐ Okay to leave message with detailed information

☐ Work Telephone _____
- ☐ Okay to leave message with detailed information

☐ Cell Phone _____
- ☐ Okay to leave message with detailed information
- ☐ Okay to send message via text message

☐ Written Communication
- ☐ Okay to mail to my home address
- ☐ Okay to mail to my work/office address
- ☐ Okay to fax to number indicated

  Fax Number _____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ Nobody

_____ Print Patient's Name

_____ Print Parent/Guardian's Name

_____ Patient or Parent/Guardian's Signature

_____ Date