ACKOWLEDGEMENT of RECEIVING
NOTICE of PRIVACY PRACTICES

Corley Family Dental
160 W McKinley Ave.
Decatur, IL 62526

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

I give permission to: Corley Family Dental to share my health information with:

_____

so that this person or entity may assist me with my health care issues.

Corley Family Dental may share my health information until I revoke the authorization.

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature acknowledging receipt of our Notice of Privacy Practices, but was unable to do, also as documented below:

Date:	Initials:	Reason: