



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may choose to not sign this acknowledgement.

I, _____ (patient or guardian) acknowledge that I am aware of the HIPAA laws and privacy policies for myself, or on behalf of _____ (patient). I am aware that I may request a copy of Ambulatory Dental Anesthesia of Montana, P.C.'s Notice of Privacy Practices for review or my personal files.

Printed name: _____

Signature: _____ Date: _____

Office Use Only

Attempts were made to obtain written acknowledgement of our Notice of Privacy Practices, but could not be acquired due to:

- Individual refused to sign acknowledgement
- Communication barriers prohibited obtaining the acknowledgement
- Other specified: _____

Completed by: _____ Date: _____