CLARK

oral & facial surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of **Clark Oral & Facial Surgery's Notice of Privacy Practices.**
I understand that this Notice describes how my protected health information (PHI) may be used and disclosed, how I can access my information, and my rights regarding my protected health information in accordance with applicable federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA).
I understand that I should keep this Notice for my records and that I may contact **Clark Oral & Facial Surgery** if I have any questions about this Notice or my privacy rights.

Printed Name of Patient: _____

Signature of Patient: _____ **Date:** _____

If Patient Is a Minor or Has a Legal Representative
Printed Name of Patient's Legal Representative (if applicable): _____

Relationship to Patient: _____

Signature of Legal Representative: _____ **Date:** _____

FOR OFFICE USE ONLY
If Written Acknowledgement Is Not Obtained
The following attempt(s) were made to obtain written acknowledgement of receipt of the Notice of Privacy Practices:

☐ NPP was provided to the patient, and the patient declined to sign
☐ NPP was mailed to the patient's home address on file
☐ NPP was mailed to an alternate address at the patient's request
☐ NPP was provided electronically (email or patient portal) at the patient's request

Reason written acknowledgement was not obtained:

_____
_____
_____
_____

Staff Member Name / Initials: _____ **Date:** _____