Belle Haven Family Dentistry

Dr. Sarah Kennealy D.D.S

HIPAA Acknowledgement and Consent

The undersigned understands that Belle Haven Family Dentistry is required by law to maintain privacy of protected health information and has provided the patient/patient's representative with a notice of its privacy practices regarding health information.

Date: _____

Patient's Name: _____ Date of Birth: _____

Patient Signature: _____

_____

Patient's Representative (if applicable) Relationship to Patient

Please check all that may apply:

- □ Office may call cell phone: _____
- □ Office may leave message on voicemail
- □ Office may leave message with spouse and/or significant other.
- □ Office should speak with patient only.
- □ Information may be given to other family members. Name/Relation: _____

_____

BHFD Office Use Only:

An attempt was made to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- □ The individual refused to sign
- □ Communication barriers prevented our obtaining the acknowledgement
- □ Other (please specify) _____

BHFD Employee: _____ Print Name: _____ Date: _____