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ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my, my Child/Children's protected health information (PHI). I have been offered or read Bay Area Kids Dentistry's Notice of Privacy Practices containing the complete description of the uses and disclosures of my, my Child/Children's protected health information. I understand that Bay Area Kids Dentistry has the right to change its Notice of Privacy Practices from time to time and that I may contact Bay Area Kids Dentistry at any time to obtain a current copy of their Notice of Privacy Practices.

I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD/CHILDREN'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

I _____, acknowledge that I have received and/or read a copy of Bay Area Kids Dentistry's HIPAA Notice of Privacy Practices.

_____ _____
Signature of Legal Responsible Person Date

_____
Print Name of Legal Responsible Person

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

_____ _____
Child Name Relationship to Child

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For Office Use Only

We attempted to obtain the Responsible Person's signature in the Acknowledgement of the Notice of Privacy Practices but were unable to do so as documented below.

Date: _____

Reason: _____

_____

_____

Name: _____

Signature: _____