

Dakota Smiles, PLLC

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

I received a copy of the Notice of Privacy Practices of Dakota Smiles, PLLC. I hereby authorize, as indicated by my signature below, Dakota Smiles, PLLC to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

Print Name

Address

Signature

Date

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at: _____
- Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI).
Please notify us if you desire to remove a name from this list in the future.

1. _____ Date __/__/____ Relationship: _____
2. _____ Date __/__/____ Relationship: _____
3. _____ Date __/__/____ Relationship: _____
4. _____ Date __/__/____ Relationship: _____

***** For Office Use Only:**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices,
but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) _____

Staff Person Initials _____