EAST TENNESSEE ENDODONTICS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
PERSONAL HEALTH INFORMATION DISCLOSURE AGREEMENT

You May Refuse to Sign This Acknowledgement

Patient Name: Date of Birth:

NOTICE OF PRIVACY PRACTICES: I have read and I understand the information contained in this office's "Notice of Privacy Practices".

PERSONAL HEALTH INFORMATION DISCLOSURE: I hereby grant permission for East Tennessee Endodontics, to disclosure my personal health information that may include financial/billing information, treatment plans and referrals, and any other pertinent dental health information related to treatment at this office to the following personal representatives.

Please print

Full Name:	Relationship:	Date of Birth:
Full Name:	Relationship:	Date of Birth:
Full Name:	Relationship:	Date of Birth:

Patient or Guardian Signature **Date**

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 acknowledgement
- ☐ Other (please specify)