Dental BLU

Ansley H. Depp, D.M.D. **Angela J. Arlinghaus, D.M.D.**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / HIPPA FORM

You may refuse to sign this document.

With the implementation of the Health Insurance Portability and Accountability Act (HIPAA) that became effective in April of 2003, it is necessary that you provide the office of Dr. Ansley H. Depp (Dental BLU) with permission to speak with other family members or friends regarding your care, when you are not available. We will do everything that we can to speak to you personally; however, if this is not possible and you would like us to communicate with other family members or friends, please fill out this form indicating whom we may share information. **By signing this form, you are also giving permission to share your dental x-rays and/or dental records with other dental/medical providers and insurance companies.**

I,_____, have received a copy of the Notice of Privacy Practices and authorize Dr. Ansley H. Depp, Dr. Angela Arlinghaus and staff to communicate information about my care to the following person/persons.

Name:_____Relationship:_____Phone:_____

Name:_____Relationship:_____Phone:_____

The Doctors and Staff of Dental BLU have my permission to:
Leave messages about my care on my voice mail/answering machine? Yes No
Send Text Messages? Yes No
Send E-Mail? Yes No

_____(Name) Please Print

_____Signature

_____Date

It is your responsibility to notify our office if you wish to change in this information.

For Office Use Only

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

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

**** We will be happy to provide you with a copy of our HIPPA privacy document when you arrive if you want one.**